THE CANADIAN NURSE

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THE CANADIAN NURSE

L'Infirmière canadienne

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JUNE 1958

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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Between Ourselves

THIS ISSUE HAS BEEN PLANNED as a special tribute to the Canadian Nurses' Association, which, at its Biennial Convention this month will celebrate the Fiftieth Anniversary of its organization. What factors influenced the nursing leaders away back in 1908 to take such a long stride forward? Fortunately for us, an excellent record of the meeting of the Society of Canadian Superintendents of Training Schools for Nurses is preserved in the pages of the December, 1908 issue of *The Canadian Nurse*. The complete text of the presidential address delivered by Miss Mary Agnes Snively also appears in that number. Her eloquent plea for support of the projected national association met with enthusiastic support. "After a general discussion, it was decided to form a Provisional Committee, and thus organize the National Association." It was the privilege of a Miss Greene, seconded by a Miss Molony to frame the momentous motion that started the train of organization moving. Our national association, today nearly 50,000 strong, began with the affiliation of eighteen provincial, local and hospital alumnae associations.

Giving us an informal, telescopic account of how that infant association thrived and some of its more important accomplishments during the first ten years is an interesting sketch by the former editor of this *Journal*, Miss **Ethel I. Johns.** Tracing the developments in nursing in general over this fifty year interval, Miss **E. Kathleen Russell,** formerly director of the School of Nursing, University of Toronto, has painted an interesting word picture that will enable us to take a fair measure of pride in our reach toward a true professionalism. The changes in the demands on their time and in the pressures under which student nurses have lived and worked in this fifty year interval are told by Miss **Elizabeth Odell.**

Then and now — 1908 and 1958! How did patients react to hospitalization in that yesteryear? What maze of duties were expected of the gallant, hard working women who carried the title of "Superintendent of Nurses"? Filling in our picture of the differences in the demands in this fifty year period is the article by **Dr. Leonard O. Bradley,** administrator of the Winnipeg General Hospital.

Many factors have contributed to the marked changes in medical practice over this half century. Many disease conditions have been virtually eliminated. The devastating epidemics of typhoid, smallpox, diphtheria have given way before improved sanitary conditions, new discoveries in medical science, nutritional research, immunization programs. As you read **Dr. Donald Fleming's** account of the startling changes, their impact on nursing can be readily visualized.

Surgery, too, has undergone many developments and improvements. Asepsis in the operating theatre was a relatively new thing in 1908. Any other form of technique is absolutely unthinkable today. The whole range of anesthesia has undergone an incredible change as **Dr. Harold Griffith** points out.

Women have been having babies for thousands of years but it is only in the past fifty that obstetrical practice has attained the high level of efficiency that presently obtains. A veteran of thousands of deliveries, **Dr. H. B. Atlee** shows clearly how the changing times have affected nursing duties and responsibilities.

We hope you will enjoy reading these journeys into then and now!

* * *

Authority *par excellence* on the history of her native heath, the Ottawa Valley, it was most natural that we should ask that versatile writer, **Charlotte Whitton,** to tell you about the historical background of our national capital. Incidentally, Ottawa during the last week in June *can* be very warm. While there are lots of stores where cool apparel can be purchased, the shopping area is quite a distance from the Coliseum where the convention will be held. Be sure you are prepared for cool or hot weather for we may have either.

Children between the ages of five and fifteen are especially susceptible to rheumatic fever. A youngster who becomes pale and listless, with loss of appetite, and complains of pains in joints, should be examined by the family doctor as soon as possible.

— Dept. of National Health and Welfare

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— Dept. of National Health and Welfare

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—*Hospitals*

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—CHARLES A. LEVINSON, *Nursing Outlook*

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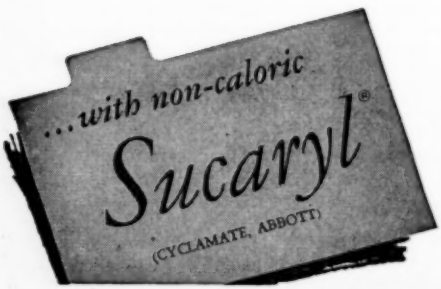

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THE CANADIAN NURSE

L'Infirmière canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
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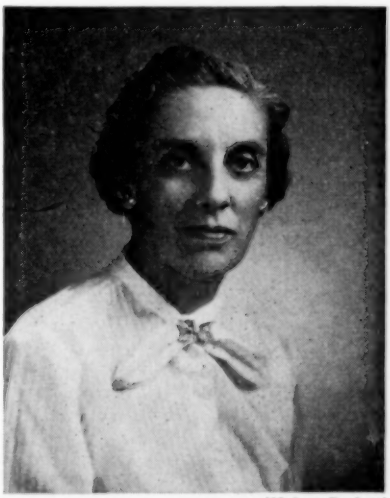
MONTREAL, JUNE 1958

Yesterday -- Today -- Tomorrow

An Appreciation

LURKING behind all institutions is a tale of human effort and interest — human effort and interest which may vary in kind and degree. It may be for self or for others, for ill or for good, for now or for all time. It may be half-hearted or whole-hearted, sincere or frivolous, spasmodic or sustained. Whatever it may be over the years, time will tell the tale through the growth and development of the institution. Assuredly, each institution charts its way across the years in direct relationship to the sort of human effort and interest which impels it. If its development is seen to be sound and progressive, in keeping with acceptable standards and in tune with the best ideals of mankind in society, then back behind the institution one finds human endeavor of the very best sort.

Such is the kind of human effort and interest which could be found behind the Canadian Nurses' Association throughout the years of its evolution. Here is a fine record of enduring achievements, the work of many devoted, energetic and far-seeing Canadian nurses: nurses who were aware of what is right and good, nurses who had an enlightened vision of the future



(Hubert Beckett)

ALMA E. REID

and who built for all time, nurses who counted not the cost to themselves but who gave generously and willingly of themselves for the sake of a cause which they deemed worthy of much faith and confidence.

Mary Agnes Snively's closing words in her presidential address at the Convention of the Canadian Society of Superintendents of Training Schools for Nurses, held at Ottawa in 1908, when the organization of the Canadian National Association of Trained Nurses was being considered, were these:

> In this closing address, I ask you to consider with me the brave women, strong and true, and the God who led and guided and helped them to make the past of our beneficent profession. We are grateful that we do not have to live the past over again, and thankful for the heritage into which we have entered. But let us all remember that privilege means responsibility; that a better century does not mean that it should minister unto us, but we to it; and also, that we can only be worthy of the great inheritance which has been bequeathed to us as we use our larger opportunities to make our country and the world better, and brighter, and purer with each succeeding year.

Surely we have here a grateful acknowledgement of the past and an enlightened vision of the future from one whose works have been an inspiration to us in the intervening fifty years. Those of us who today enjoy the labors of the architects of professional nursing in Canada are deeply indebted to them. Our debt to them for their vision, courage and wisdom is beyond estimate. It can only be repaid through the kind of service which they expected from us.

Too often we are inclined to look solely at the present and here we find much that does not satisfy. In place of satisfaction we are liable to find frustration and discouragement. True, from such feelings progress may often germinate. Albeit, without an appreciation of what lies behind our present state, without any knowledge of where we came from and by what route, we may easily succumb to our low feelings or "take off" in the wrong direction. Santayana in his *Life of Reason* says, "Those who cannot remember the past are condemned to repeat it." To be mindful of the past, to respect it, to understand it and to learn from it gives us real sustenance and inspiration for what we are about to build today and in the future. We must not forget the past or trample upon its traditions.

Yet, to be lulled into complacency through the soporific effect of a worship of the past could be likewise disastrous. To-day, while mindful of the past and custodians of the traditions of the past, we must ever be alive to our present and future obligations and responsibilities. Today is tomorrow's history. As with those who have gone before us, we must possess an equal alertness of vision as we look ahead, an equal courage as we meet new opportunities and an equal degree of wisdom and understanding as we face the many challenging problems which are ours in nursing.

It is our hope that, in another half century, our successors in the Canadian Nurses' Association may be able to pull back the curtain and see the same kind of human effort and interest which we see today as we view in retrospect the work of our predecessors. What better watchword could we have chosen for this biennium than, "Into the future, open a better way"! It could fittingly be adopted for the second half of our centennial.

ALMA E. REID
Immediate Past President,
Registered Nurses' Association of Ontario.

Wonderful News

Just as this issue goes to press word has been received that the W. K. Kellogg Foundation of Battle Creek, Mich. has promised a quarter of a million dollars, to be spread over a period of eight years, to assist with the establishment of a School of Nursing at the University of New Brunswick. When established the school will offer a four-year degree course in nursing.

Our City — Your Capital

CHARLOTTE WHITTON, C.B.E., LL.D.

NURSES FROM ALL PARTS of Canada will be gathering in Ottawa. Here, where the Canadian Nurses' Association first took form half a century ago, Ottawa's nurses will be at home to their colleagues in one of the oldest and noblest of callings followed by womankind.

Canada, just entering her ninety-first year, is herself so young in her Confederation that even this small and somewhat uncertain city is itself older than the nation whose government it shelters. So, there will be few of you, except those from our far west and northern lands, who do not come from settlements older in their history than Ottawa. None can claim a heritage older in the years of time and of God than those of us who belong on The Ottawa — our City on its own mighty river. It is yours too, every Canadian in this land, by reason of its being your Capital.

We of the Ottawa watershed, born and bred along The River and its tributary streams, say "We belong in The Valley." It is a mighty valley, The Ottawa in its 780 miles — only 50 miles less in length than the Rhine. Twenty-two rivers drain The Valley's 70,000 square miles.

The blue, blue hills; the great rock masses that are the very structure of The Valley are among the oldest such formations in the world, much older than the Himalayas. They were cooled, formed and in place a thousand million years ago. Five hundred million years ago, great waters rose and rolled over these rock stretches, completely submerging them. Through long eons, these engulfing waters receded, rose again, flowed in upon the whole Eastern Ontario region of today, and washed back and forth in numerous invasions of the sea.

As the prehistoric waters ebbed, glacial formations, moving southward over the earth's surface, gathered up the great rock masses carrying them and the soil, into which they were ground, before them and rounding our Laurentian and Gatineau Hills into the soft and gentle curves which glow purple in the gracious closing of the twilight or gleam to the sunrise of the day's awakening.

Other glacial masses, melting northward, formed a great prehistoric inland sea — Lake Barlow, 1,000 feet above sea level. It covered most of the present rich mining country of northern Ontario and northwest Quebec. Lake Timiskaming, beautiful and gleaming, formed in the draining off of these primeval waters, and grand Lake Victoria, a fisherman's paradise in The Ottawa's head waters, were probably the centre of the floor of this vast and mysterious lake, brooding in its silence, those many thousands of years ago.

Yet once again the primeval waters were to engulf the land that is our Valley today. Twenty-five thousand years ago the jealous invading sea again rushed over all our lands, swirling northward as far as the Pembroke-Petawawa-Deep River area then south and westward to present-day Brockville on the St. Lawrence. The Ottawa's northern hills probably mark the sentinel range that withstood and tossed back these last ruthless tides of the ancient geological seas, while the Thousand Islands and St. Lawrence shore likely mark their southernmost thrust.

(Karsh)

CHARLOTTE WHITTON

Miss Whitton, formerly the Mayor of Ottawa, is abundantly steeped in the lore of The River and her beloved city of which she writes so affectionately.

Only as these waters at last receded eastward to the sea did the ravaged hills and plains bring forth the richness of their forest growth — the pine and spruce and hardwood, their tossing plumes of darkling green or flaming autumn foliage still riding the ridges of our encircling hills in a radiant glory that is peculiarly our own.

When, or where or how human life emerged within these forested fastnesses, we know not. All those thousands upon thousands of years our Valley lay in the silence and hand of God. But when, scarce three and a half centuries ago, in 1610, Samuel de Champlain, who had founded Quebec two years earlier, learned from the native Indians of a great waterway thrusting ever westward, he sent Etienne Brulé to report upon it.

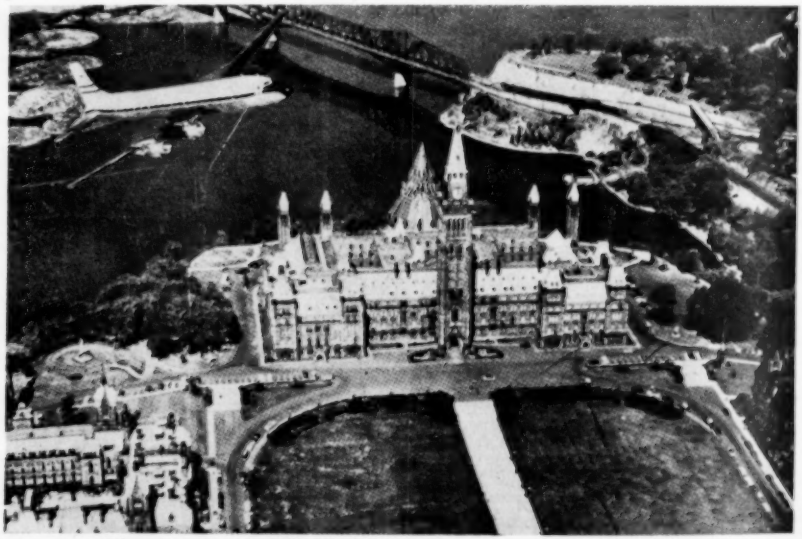
The Algonquin Indians, then dwelling in The Valley with well established camps, routes, trails and tribal life, welcomed the first European to come among them and taught him their language. *Kit-chi-sippi* — the Grand River — they called The Ottawa, and told how, far in its upper hidden waters and forests, dwelt their great god Manitou — on the Manitoulin Island of today.

Not until 1615 did the illustrious Champlain himself find the route of what we know now as "the old Champlain trail" — up The River to Georgian Bay, thence north and westward to Lake Huron, the Sault and Lake Superior, then returning southward through the Kawarthas and the Trent Valley to Lake Ontario.

It was on Lake Nipissing in that year that Champlain first met the tribe of the Algonquins who dwelt in the Islands of Manitou — the Outaouas or Outawis of the Kitchisippi, and from whom we were to take the name of both our City and our River.

There has been much dispute, always, as to the literal translation of Outawi. One interpretation is "human ear" — not without relevance in a centre of such rumor as a national Capital. Others say it was the tribe of the "raised hair." Certainly those who watch governments and others in action have often felt their own hair stand on end in reaction. And the third connotation, "those who come out of the woods to trade," could have a variety of applications, none of them wholly inapplicable to people and events at the seat of government.

By the Champlain route along the Kitchisippi or La Grande Rivière, trade and missionary enterprise moved for only a few years, however, because the fierce, ranging Iroquois tribes overran and laid waste all the land. The Canadian martyrs Bréboeuf and Lalemant, who had gone this route to the Huron



The plane bearing H. M. Queen Elizabeth, *as it circled over the Parliament Buildings in October 1957.*

missions were among their victims. Not until 1654, when the Outawis from their inner waters swept down the tempestuous, turbulent River and ambushed and captured a large Iroquois encampment, was The Ottawa route open again.

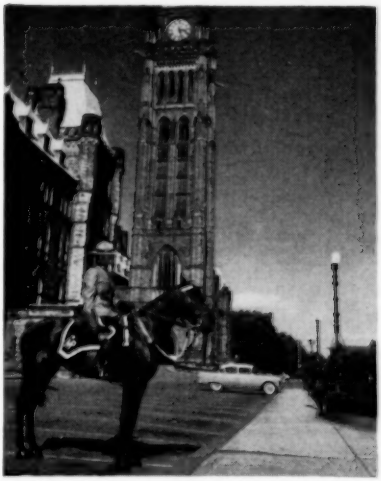
Gradually, in spite of its heavy portages, La Grande Rivière des Outawis became the favored route — shorter and less perilous for the voyageurs, in their frail canoes, than the wind-swept St. Lawrence and the Great Lakes, with the marauding Iroquois and the expanding New England settlements thrusting ever northward and contesting French sovereignty in the new land.

So The Ottawa became the route by which the great French missionaries and explorers were to travel, through forest and by mighty waterways, to open all the west to the head of Lake Superior and by Lake Michigan and other waterways, southward even to the Mississippi. Access to all the midwestern United States and Great Lakes cities was first by this way.

Now the battle for power was joined between a declining France and an expanding Britain on three continents. Canada and The Ottawa were to be spun on this whirling wheel of destiny.

There came the fall of Quebec and the first English traders up The River — Alexander Henry in 1761. With the whole continent under one sovereignty, The Ottawa, tumultuous, vast, forbidding, far from the sea, was not as favored for settlement as the rich, more accessible lands of the St. Lawrence, the shores of Lakes Ontario and Erie. Only a few bivouacs marked the Ottawa country, which was set aside officially for the fur trade as "all the derelict country to the west." (If the people of Ottawa at times seem to "take it out" on the Maritimes, Quebec, and especially the prosperous Lake Ontario communities, it might be remembered that we have had due provocation and are only working out a grudge of 200 years' standing.)

Within a few years of the passing of New France to other sovereignty, the most momentous change in modern European history was to break upon this continent and again to twirl the destiny of Canada and The Ottawa in mad gyrations. The American Revolutionary War had deprived Britain,



A familiar sight on Parliament Hill.

desperately battling in a Europe torn by the French Revolution, of the vast overseas resources of the dynamic young United States. The Admiralty contractors of the Crown turned to the great and unknown timberlands of Acadia, Quebec and The Ottawa in search of the fine white pine for the timbers and masts of the Navy.

Just up The Ottawa, about fifty miles or so, to this day there may be traced the trail of "the Old Mast Road." There, in those first years of the last century, the great white pines were felled, men, women, and children with primitive settlers' axes and hand labor bringing them down, trimming them — 120 feet tall to the first cross-branches, some of them — and then with oxen hauling them out to float down The Ottawa, for rafting and river driving, all the way to Quebec. There, loaded on to the King's ships, they went to form masts for the men-of-war. Such ingredients compose the story of The Ottawa and many another forested river whose timber went into the fighting ships that battled all the way from the Nile to Trafalgar and the long years through until Napoleon's final defeat at Waterloo.

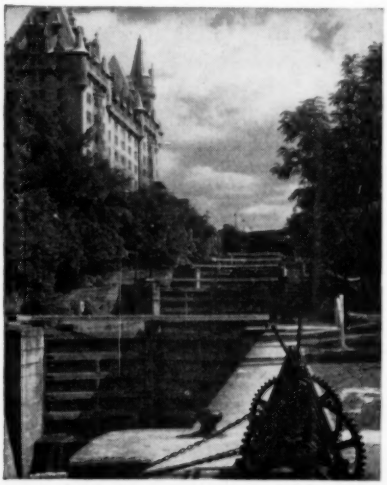
By-product, too, of the American Revolutionary War, affecting The Ottawa and bringing the first permanent settlers into the immediate Ottawa area, was the movement of the United Empire Loyalists from New England to

these newly-ceded territories to the north. Into New Brunswick, Nova Scotia, the Eastern Townships and the new Province of Upper Canada they thronged, founding their new settlements of free men, determined to govern their own lives but to hold, along with the 65,000 new French-speaking subjects of the Crown, the northern half of this continent as their own and in firm allegiance to the king.

Strong, vigorous, courageous, stubborn in their resistance to invasion, within a generation they almost lost their second new homeland in the War of 1812. Disaster threatened because all the inner land lacked a safe inner way from the St. Lawrence and Great Lakes to this upper country with its great resources of land and forest.

Wherefore, that war over, the British government projected an engineering feat as great in its day as the St. Lawrence Seaway in ours — the Rideau Canal. Thrust through dense forests and 132 miles of waterways from the Cataraqui at Kingston it steps down graciously here by its nine locks to The Ottawa, just where the Parliament Buildings and the Chateau overlook Entrance Bay, then called Sleigh's Creek and formed by an overflow from a 12-acre beaver pond where now the Union Station stands.

The work was entrusted, on the choice of the Duke of Wellington himself, by that date Prime Minister, to Colonel John By, who had served already at Quebec and gone through the Peninsular War. With him came companies of the Royal Engineers.



The Rideau Canal meets the Ottawa River

When Col. By founded his construction camp near the Forks of the Rideau in 1826-7, there were only a few settlers here. Among the foremost was Nicholas Sparks, an Irishman, who had come up The River in 1819 to work with Philemon Wright, a Kentishman from Woburn, Massachusetts. Wright in 1800 had founded the flourishing settlement of Hull and proven that it was possible to drive the timber of The Ottawa by crib and rafting, through great slides built about the churning rapids of our River, and so had found a direct line of shipping from The Ottawa to the sea.

The Rideau Canal opened new routes to the timber trade, to the St. Lawrence, across the St. Lawrence via the Oswego Canal, via Lake Champlain, via the Erie Canal to Buffalo. Everywhere moved the fine timber of The Ottawa, squared, then later sawn, to every market of the world. Timber was king and Bytown, soon to become a city with the name of the original courageous tribe of Indians whose river ours had been, was the heart of the timber trade.

The United States was throbbing with its westward expansion. The states of Europe and the provinces of the Atlantic seaboard and Central Canada were restless in the general surging for free and responsible government of men everywhere. The tides of time and the dictates of trade and commerce were moving alike inexorably to the union of Upper and Lower Canada. When, after the rebellions in both provinces in 1837-8, the union came about, in the creation of the Province of Canada (our Ontario and Quebec), it was an uneasy and unhappy one. Old animosities and current jealousies defeated agreement, particularly as to the seat of government, which rotated finally between Quebec City and Toronto every four years.

In the bitterness of contesting claims, the historic reference was made to Her Majesty, Queen Victoria. One hundred years ago last New Year's Eve (December 31, 1857) an unbelieving country learned that

> in the judgment of Her Majesty, the City of Ottawa combines more advant-

Wellington and Bank Streets, Ottawa, about 1853.
Taken from a water color by W. H. Thompson, after Lieut Sedley, R.E. 1853.

ages than any other place in Canada for the permanent seat of the future government of the Province and is selected by Her Majesty accordingly.

There were still months of bitter debate before, on February 10, 1859, the Queen's choice was confirmed. Before the Parliament Buildings in the new Capital were erected, the Confederation of Nova Scotia, New Brunswick, Quebec and Ontario into one Dominion was effected. Finally on October 10, 1865, the seat of government of all Canada was permanently fixed at Ottawa, a choice confirmed with the proclamation of the British North America Act on July 1, 1867.

So, our proud past on The Ottawa became *your* past. Our City, older than the Dominion, became the Capital of the newer, younger country. In our care and keeping, we people of Ottawa protect and serve all the civil life of this city wherein the heart beat of this nation throbs. We are proud, we people of The Ottawa, but all that we have or are is offered in our trusteeship to the people of Canada and to Her Majesty, the Queen, as the Capital of the senior Dominion of the Commonwealth.

It is said that we are "a hard city to know." Could it be otherwise, since, year in and year out for close to a century now, our life has flowed on, not only in the normal growth and natural maturing of its own character but monthly fed by the life streams which come to it from all the other areas of Canada? The civil servants, brought into government here, are bred in other communities. They know and love them more intensely than this their adopted city. To them, the Parliament Buildings and the government offices, wherein their own work centres, offer a more realistic and vital focus of loyalty than this old city of The Valley, as different from all other towns in this land as is our own Irish-Scottish accent, marked often with a clipped French turn.

Superbly placed in its forest robing upon our great "Rockcliffe," rides Government House where, symbol of the unity of all our past and the nobility of our present, the representative of the Sovereign maintains the ancient high honor and inspiration of the Crown.

All about and through the City are the ambassadorial residences of the distinguished emissaries of the friendly powers, accredited to us in the name of our Queen.

To "The Hill" foregather in their seasons, the members of The Commons and The Senate with all their attendant

Photos supplied by

Ottawa Tourist and Convention Bureau

The Supreme Court of Canada

train of sessional interests. They live intensely with us for a few short weeks and then they recede again to the centres which they love more and best.

Royal Commissions come and go and the bones of their reports lie bleaching among the prehistoric fossils upon Parliament Hill. The Supreme Court, in dignity and detachment, dispenses the last justice available in the land.

Through our City, silver-laced with the gracious waterways of The Rideau system, all tributary to the great Ottawa itself, the men and women who are the real townsmen of the community go about their work as they have this century or more. The City runs eastward, westward along "The River" for nearly 12 miles to "the Hog's Back," and the beauteous Rideau River Rapids to a maximum depth of seven miles. It cannot go northward for there The Ottawa severs, even as it joins, our life and that of the other jurisdiction of Quebec.

One-tenth of all our area is water — the Ottawa, the Rideau River and Canal, and beautiful Dow's Lake, the basin into which Colonel By drained Dow's great swamp of the original settlement at the Forks. With 45 miles of waterfront, we are a city of bridges — and even more bridges. Three of them are shared with the Province of Quebec and the "north shore" communities of that province of which our older sister city, Hull, 95 per cent French-speaking, is the largest. Up and down The Ottawa, in the area of the Capital, lie the Valley's farming and industrial communities, Ottawa still their natural centre.

Beyond, on the north shore, the splendor of the Gatineau Hills gleams as it has these centuries. On our south shore, the Laurentians still keep silent company through the hundred-odd miles of glorious country, to "The Deep River" on the Upper Ottawa, where the most modern of all man's strange new ventures is a-making — the nuclear research plant of the National Research Council.

Twenty-three different races meet within Ottawa's confines, the largest area but one of any Canadian city, but we are still predominantly of our original founding fellowship.

The old French strain lives largely east of "The Canal," where on a Christmas Eve, by a soaring Gothic church, a gloriously simple crib of our own Ottawa timber portrays the Christmas Story to the hurrying traffic, swirling at a corner that was a crossroads in the early swampland.

Here, too, you will meet upon "The Markets" anyone from a Judge of the Supreme Court, getting his *foie-gras*, to your newsboy buying his corn to pop or a Cabinet Minister's wife bearing off Gatineau ducklings for her Embassy dinner.

West of The Canal stretches Upper Town, divided like Caesar's Gaul into three parts. Centre Town, crowded and as loved as old-fashioned, is a sheer madness to those who know not our short streets and narrow ways, and that the two streets of Sparks and O'Connor were designed by these two founders of the City to form the arms of the Cross.

The Glebe and Ottawa South are the solid Anglo-Saxon centres, built in part on the old clergy reserves.

In the West End, southward in the Billings Bridge area, are the fine settlements of the oldest of our land patentees, many of their descendants still tilling their farms — several of them within the City limits — and many of which were recorded before there was even a trading post at Nepean Point. Everywhere in our enlarged environs are the thousands of new homes built since the last war and the churches, schools and services they have called into being.

Yes, we live and go our own way by our own Great River.

Ottawa is cynical? A bit, but not wholly so. However, we do, I think, take on something of the living unto ourselves of the mighty Ottawa which has seen life come and go upon its banks for those eons before the memory of man, as the people of Ottawa have seen men come and go, have heard the plaudits of the country as new men have taken over her government, have seen them slave and suffer for this land, have seen them crucified by those who called them friend and others move in, with pageantry and pomp to go the self-same way.

And yet life goes on and all things move together to fulfil destiny in the working out of God's plan, to faith in whom, the graceful spires, the solid dignified structures, the devoted discipleship of Ottawa's fine churches, educational and charitable institutions bear hourly witness as the noon gun booms from "The Hill" and its echoes are caught up in the answering peals of convent, church and chapel.

Dominating the very heart of the Capital, where the Canal steps down to the River, stands this nation's memorial

Canada's Memorial

to those who gave their all in the day of battle and to whose sacrifice another generation in another war have added their tribute of brave youth laid low. They died believing this Canada, this City, mine and yours, were worthy their good living and noble dying. Let us keep faith with them and

> Seek a City splendid
> With light beyond the sun
> Or lands where dreams are ended
> And work and days are done.

Into the Future A Better Day

EDNA E. LEVELTON, R.N.

In the near future, help us find
A way to open for mankind
A door — a door where nurses lead the way
Into a new and better day.

May we, whose duty is to serve,
Search deep our hearts and never swerve
From seeing, and living out the truth,
That by our lives we give the proof.

The proof that herein lies new health,
Because we're free from thought of self,
Free from all worry, free from greed,
Free to meet well a nation's need.

Give us a passion for the right,
To give ourselves in this great fight,
That in our dedication true
We'll bring to nursing something new.

The First Ten Years

ETHEL JOHNS, LL.D.

DURING the early summer of 1893, the World's Columbian Exposition was in full swing in the city of Chicago. Among the many assemblies that took place under its auspices was that of the International Congress of Charities, Correction and Philanthropy. The director of the section of the Congress that was concerned with hospitals and dispensaries was Dr. John S. Billings, supervisor of construction and organization at the Johns Hopkins Hospital, and it was he who had appointed Isabel Hampton, superintendent of nurses in that institution, to be the chairman of the sub-section which dealt with nursing affairs.

In view of certain developments that subsequently took place, it is interesting to note that shortly before this meeting of the International Congress, the redoubtable President of the British Nurses' Association, Mrs. Bedford Fenwick, had paid a preliminary visit to Baltimore and had there conferred with Isabel Hampton, Lavinia Dock and Adelaide Nutting. Little is known of what went on during this brief encounter but it soon became evident that it was to have a profound effect upon the nursing profession in several countries and for some years to come.

ETHEL JOHNS

The content of the program for the sessions of the sub-committee does, however, shed considerable light on what this remarkably able group of women had in mind. Although Florence Nightingale was not able to be present, she had prepared an address, bearing the significant title of "Sick Nursing and Health Nursing," in which she set forth her conception of the role of the nurse in the public health field. Isabel Hampton had been given the privilege of speaking before a general meeting and chose "Standards for Nurses" as her topic. The fiery Lavinia Dock put forward some highly revolutionary ideas about the relation of schools of nursing to hospitals that must have made Dr. Billings and other administrators wonder whether it had been prudent to grand this radical group an opportunity of airing their views before so distinguished an audience.

At every session, emphasis was placed on the need for organization. Isabel McIsaac spoke of the value of alumnae associations, and Edith Draper, shortly to take over her new duties as the first Lady Superintendent of the Royal Victoria Hospital in Montreal, went a step further by urging the necessity for "an American Nurses' Association." It was during the discussion of this address that the impact of that preliminary conference in Baltimore began to make itself felt. Isabel Hampton contended that the formation of a superintendents' society must necessarily precede any other organization on a national basis and suggested that immediate action should be taken "before the Congress adjourns and while the English group is still here to give advice." As might have been expected, Mrs. Bedford Fenwick promptly rose to the occasion and struck while the iron was hot. Then

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A former editor of *The Canadian Nurse*, Miss Johns played a prominent role in the early activities of the Canadian Nurses' Association. She resides now in Vancouver, B.C.

and there, the first steps were taken to set up the American Society of Superintendents of Training Schools for Nurses of the United States and Canada. Among its charter members was Mary Agnes Snively who, since 1884, had held the position of Lady Superintendent of the Toronto General Hospital.

Although the concept of an International Council of Nurses was in the air at the Chicago meeting, it was not carried out in terms of action until six years later. During the interval, the Nurses Associated Alumnae of the United States and Canada came into being and, upon receiving a charter from the State of New York, was renamed the American Nurses' Association. Although the leaders on both sides of the border kept in friendly touch with one another, it soon became evident that organization on this basis would not function smoothly in Canada. Thus, in 1907, the Canadian Association for Superintendents of Training Schools for Nurses was founded by Mary Agnes Snively.

Early in the following year, Miss Snively's watchful presidential eye noticed a challenging statement in *The British Journal of Nursing*. Mrs. Bedford Fenwick, by this time Founder and President of the International Council of Nurses, had this to say:

> At the next meeting of the triennial congress of the International Council of Nurses, to be held in London in July 1909, Denmark, Finland and Holland will be received into membership, these countries having completed the organization of their respective national organizations.

Miss Snively herself was a founding member of the International Council and was serving in the capacity of honorary treasurer. But Canadian nurses were not yet organized on a national basis and Canada could not claim the corporate membership accorded to more enterprising European nations.

Obviously, this would never do! With characteristic courage and energy, Miss Snively forthwith summoned a meeting of the executive committtee of the newly-formed Canadian Association of Superintendents of Training Schools for Nurses. It was decided

> to invite various hospitals and training schools throughout Canada to confer with the Superintendents' Society at its annual meeting in order that the advisability might be considered of proceeding to form a Canadian National Association.

A cordial response came from all parts of the country and on October 8, 1908, "eighteen organizations of nurses met by delegation in Ottawa to form the Provisional Society of the Canadian National Association of Trained Nurses." It goes without saying that Mary Agnes Snively was elected as its president.

Among the nursing groups represented by delegates, two only — the Graduate Nurses' Association of Manitoba and the Graduate Nurses' Association of Ontario — were then organized on a provincial basis. Six groups were composed of graduate nurses from various schools who were engaged in active practice in the larger urban centres. Seven Alumnae Associations were also represented, all of them situated in the Province of Ontario.

No time was lost in applying for membership in the International Council and it was accorded with enthusiasm:

> Canada is a very dear daughter in the chaplet of England's imperial crown of womanhood and her nurses are second to none . . . One can hardly realize the warmth of welcome that will be extended to the daughter association of Canada when the Mother Council takes her by the hand and, in some historic sphere of healing, presents her as a link in the chain that binds together the nurses of the world in international unity.

All this from the Founder and President of the International Council of Nursing, a staunch Imperialist if ever there was one!

Five representatives of the Provisional National Association were appointed as delegates to the forthcoming International Congress, three of them from Toronto and two from Montreal. In addition, twenty more Canadian nurses attended on their own behalf — thirteen came from the Province of Quebec, five from Ontario and two

hardy souls from as far west as Winnipeg. During the ceremony that marked the reception of Canada into membership, Miss Snively gave a vivid picture of the Canadian nursing scene:

> There are seventy schools, ranging in size from ten to a hundred pupils, and stretching from the Atlantic to the Pacific Coast. The school nurse has begun her beneficent work . . . The district nurse becomes more indispensable each year, and relief and tuberculosis work are actively carried on.

There was one area, however, in which Miss Snively was forced to admit that little progress had so far been made:

> Canada has made three unsuccessful attempts to secure registration for trained nurses. She is not discouraged, however, but hopes the not too distant future may bring the much desired good. The law of worthy life is fundamentally the law of strife. It is only through labor and painful effort, by grim energy and resolute courage that we move on to better things.

At the conclusion of Miss Snively's address "the four hundred nurses attending the Congress rose to their feet while the strains of The Maple Leaf and the National Anthem resounded through the hall."

Lavish hospitality was extended to the visitors and the Canadian delegates were even permitted to lay a wreath on the tomb of Queen Victoria — "a privilege which had been refused two of His Majesty's nephews a fortnight previously." In the harsh light of today, all this seems no more than a fading dream but for those who shared it there was a deep significance. This was the romantic age of nursing.

At the first general meeting of the CNATN, held in 1911, it was realized that a constitution and bylaws would have to be adopted before the Association could function effectively. Under the provisional set-up, three types of membership had been suggested: provincial associations, urban associations, and alumnae associations. An equitable system of voting had not yet been worked out when in 1916 the present writer first became actively interested in the affairs of the CNATN. The Manitoba Graduate Nurses' Association was then deep in preparation for the first general meeting of the national association ever to be held west of the Ontario border. Every possible source of entertainment was canvassed and an indefatigable reception committee met every train. There was a relentless round of teas, luncheons and banquets. By the end of the week, the dignitaries from the East were visibly impressed if not entirely bowled over. At least, we thought they were!

In spite of distracting responsibilities, the members of the Manitoba Graduate Nurses' Association managed to keep an eye on what was going on at the regular sessions. The problem of corporate membership had not yet been solved but a good beginning had been made. The formation of a public health section came up for consideration. *The Canadian Nurse* at last became the property of the CNATN. To one onlooker, the honorary secretary, Jean Isabel Gunn, seemed to stand head and shoulders above everyone else. The clarity of her thinking, her firm grasp of essential principles, her unfailing sense of humor gave ample proof that here was a leader worthy of the name.

After the visitors had gone their separate ways, the Manitoba Graduate Nurses' Association felt free to rest upon its laurels. Surely it had been demonstrated that Manitoba had a place on the map of Canada. But the following Spring, when the report of the CNATN nominating committee arrived from the East, it did not contain the name of a single Manitoban! There was a stunned silence until a voice at the back of the room suggested that someone should be nominated anyhow. "It doesn't matter who — she hasn't a chance of getting in." A member rashly allowed her name to stand for the office of honorary secretary — simply as a protest of course. No chance of election.

The 1917 general meeting of the CNATN took place in Montreal and the delegates were greeted by Gertrude Elizabeth (Nora) Livingston who for 27 years had held with great distinction the position of Lady Superintendent at the Montreal General Hospital. Her remarkable career had been devoted almost entirely to the building up of the

famous School of Nursing of which she was the head. The records show that

> she never travelled to or attended any conventions or gatherings of nursing bodies. But she fully realized the value to be derived from them and would always send representatives from her staff to attend them.

On this particular occasion, however, she duly appeared in person, wearing a black silk dress and a small hat, rather like a Victorian bonnet, trimmed at the side with a bunch of violets. Then in her seventieth year, her natural force was not abated and her bright eyes looked us over as if asking us what we were doing so far from our regular duties. "I hope your patients are being well looked after during your absence," said Nora Livingston, with a rather quizzical smile.

One of the prairie delegates still remembers that first glimpse of the Royal Victoria Hospital in its magnificent setting in the slopes of Mount Royal and her encounter with Mabel Frances Hersey, later to become guide, philosopher and friend in trials and tribulations not then foreseen. The days slipped by so happily that the Manitobans forgot all about that protest nomination until the election was actually under way. Jean Isabel Gunn was elected president and given a rousing welcome. Then, the unexpected happened! The Eastern nominee for the secretaryship withdrew her name, there were no nominations from the floor and the luckless Manitoban went in, more or less by default, greeted by a perfunctory patter of applause. She retired to her room in a low state of mind to think the situation over. Then the door opened, and Jean Isabel Gunn came in. Under her arm was a bulging brief case which she proceeded to sort out methodically. "Well, it looks as though we are the goats," said she, "let's get on with the job." Suddenly, it seemed as though Toronto might not be so far from Winnipeg, after all.

There was plenty to do. The War was going badly and the demand for military nursing service had become so great that it could hardly be met without crippling the civilian hospitals. It became evident that a coordinated plan for nursing service would have to be formulated and it was in this connection that Miss Gunn's outstanding capacity for organization and administration came into play. Slowly but surely, governmental and military authorities began to realize that this woman knew what she was talking about and that the professional association of which she was the head was a force to be reckoned with. Her accomplishment is all the more remarkable when it is remembered that the CNATN had very little money, no headquarters and no paid secretarial staff.

Faced with a similar wartime crisis, the American Nurses' Association was in a far better position to cope with it. Adelaide Nutting, by this time head of the department of nursing and health at Teachers College, Columbia University, was directing the activities of the National Committee on Nursing in the United States. It seemed natural to call her into counsel and she was the principal speaker at the 1918 general meeting of the CNATN, held in the West Hall of the University of Toronto. As she approached the platform, it could be seen that she was deeply moved. Like Isabel Hampton, Adelaide Nutting was a Canadian by birth and ancestry and so remained throughout her long life, although she also gave loyal allegiance to the country of her adoption. Her keen historical sense must have reverted to that meeting in Chicago when the American Society of Superintendents of Training Schools for Nurses of the United States and Canada had come into being. Now, a quarter of a century later, the Canadian Association of Trained Nurses, which had stemmed from it, spoke with authority for the nurses of Canada. The wheel had come full circle.

Nevertheless, much remained to be done, especially in obtaining legislation which would govern registration in the various provinces. As early as 1911, the CNATN had made a gallant though unsuccessful attempt to secure Dominion-wide registration by setting up a committee with this end in view. In 1913, the committee reported that

> it is of vital importance that there be

uniformity of standards and that the training and registering of nurses be the same, fundamentally, in all parts of Canada . . . The plan of the committee is to have representatives from each province prepare the best bill for that province. When all these bills are prepared, the committee will take them, compare them, and from the nine bills prepare a model bill which would incorporate all the good points of each.

Although this particular problem turned out to be far more complicated than the committee had fondly imagined, the CNATN did succeed in setting up standards for schools of nursing. Its influence began to make itself felt to a surprising extent all over the country. One example among many is the recommendation approved in 1918 by the training school committee of the Winnipeg General Hospital:

> That the educational standards of our Training School be raised by adopting as nearly as possible the standard curriculum accepted by the Canadian Association of Trained Nurses.

In retrospect, it can now be seen that the year 1918 marked a turning point in the history of the CNATN. As soon as the war was over, public demand for the expansion of nursing service, especially in the public health field, became so insistent that it could no longer be ignored. Rather reluctantly, one Canadian university after another yielded to an appeal for courses for nurses wishing to qualify as teachers and supervisors. The door was not wide open but neither was it closed. At this critical juncture, clear thinking and resolute action were needed at the national level and the CNATN proved itself capable of providing both.

What had the Canadian Nurses' Association accomplished during that first decade? To begin with, much had been done to overcome the barrier of distance that isolated the eastern and western provinces from one another — a barrier that was not only physical but psychological as well. Even though there was still no headquarters and no paid secretarial staff, there was a national rallying point where Canadian nurses could take counsel together. They did not fully understand one another for they had not yet realized that Canada is, or ought to be, a bilingual nation. That was to come later.

The Association had also freed itself from a tutelage (American as well as British) which, although helpful at the outset, might eventually have inhibited independent thought and action. Already it was capable of seeking its own destiny while continuing to maintain friendly relationships south of the border and overseas. Now it became evident that both the scope and the policies of the national organization would have to be considerably broadened if it was to keep in step with the rapid development of the provincial associations. The time had come for the Canadian Association of Trained Nurses to strike its tents and begin its march toward a new horizon. But that is another story!

Les Dix Premières Années

ETHEL JOHNS, LL.D.

AU DÉBUT de l'été de 1893, l'exposition universelle, dite colombienne, était en pleine activité, à Chicago. Parmi les nombreuses sociétés qui s'y sont réunies, se trouvait le Congrès International de Charité, Correction et Philanthropie. Ce congrès comprenait une division des hôpitaux et dispensaires, laquelle était dirigée par le Dr. John S. Billings, surveillant de la construction et de l'organisation du "Johns Hopkins Hospital" et c'est lui aussi qui avait nommé Isabel Hampton, alors directrice des infirmières à cette institution, présidente de la sous-division du nursing.

Si l'on considère certains développements survenus par la suite, il est intéressant de noter que quelque temps avant le congrès international, la redoutable présidente de

l'Association des Infirmières Britanniques, Mme Bedford Fenwick, s'était rendue à Baltimore et avait eu un entretien avec Isabel Hampton, Lavinia Dock et Adelaide Nutting. Bien peu de choses ont percé de ce court entretien mais il fut bientôt évident que cet événement aurait sa répercussion sur la profession d'infirmière dans plusieurs pays et pendant quelques années à venir.

Le programme des séances de ce sous-comité, tout de même, nous éclaire beaucoup sur les idées de ce groupe de femmes habiles et remarquables. Bien que Florence Nightingale n'ait pu assister à ce congrès, elle avait préparé un travail qui portait ce titre de grande portée: "Sick Nursing and Health Nursing" que nous traduirons: "Le Nursing curatif et le Nursing préventif," et dans lequel elle donnait sa conception du rôle de l'infirmière en hygiène publique. Isabel Hampton, ayant eu le privilège d'adresser la parole à une assemblée générale, avait choisi comme sujet de son allocution: "Normes pour les Infirmières." L'ardente Lavinia Dock présenta des idées vraiment révolutionnaires sur les relations entre écoles d'infirmières et hôpitaux qui ont sûrement dû porter le Dr. Billings et les autres administrateurs à se demander s'il avait été bien prudent de donner à ce groupe radical l'occasion d'exposer son point de vue devant un auditoire si distingué.

Au cours de chaque séance l'on revint sur la nécessité de l'organisation de la profession. Isabel McIsaac parla de la valeur des associations de diplômées ou amicales et Edith Draper, qui devait peu de temps après devenir la première directrice de l'Hôpital Royal Victoria à Montréal, alla plus loin et parla de la nécessité d'avoir une "American Nurses' Association." C'est pendant les délibérations qui suivirent ce discours que l'effet de la conférence préliminaire de Baltimore commença à se faire sentir. Isabel Hampton a soutenu que la formation d'une association de directrices s'imposait avant de penser à une organisation nationale et suggéra que l'on se mette à l'oeuvre immédiatement "avant la fin du congrès, afin de profiter de la présence du groupe anglais susceptible de donner des conseils." Comme on devait s'y attendre, Mme Bedford Fenwick se montra à la hauteur de la situation, se disant qu'il faut battre le fer quand il est chaud. C'est ainsi et alors que les premières dispositions furent prises pour l'institution de l' "American Society of Superintendents of Training Schools for Nurses of the United States and Canada." Sur la charte de cette association se trouve le nom de Mary Agnes Snively qui, depuis 1884, occupait le poste de directrice au "Toronto General Hospital."

Bien que l'idée d'un Conseil International d'Infirmières fut dans les esprits lors de la réunion de Chicago, cet organisme ne fut toutefois fondé pour toutes fins pratiques que six ans plus tard. Entre temps, les amicales unies des Etats-Unis et du Canada prirent naissance et reçurent leur charte de l'Etat de New York sous le nom de "American Nurses' Association." Les chefs de files, tant aux Etats-Unis qu'au Canada, entretinrent des relations amicales mais il fut bientôt évident qu'une organisation de ce genre ne pouvait fonctionner harmonieusement au Canada. Il s'ensuivit qu'en 1907 la "Canadian Association for Superintendents of Training Schools for Nurses" fut fondée par Mary Agnes Snively.

Au début de l'année suivante, l'oeil scrutateur de notre présidente, Mlle Snively, nota, dans le "British Journal of Nursing" une nouvelle qui ne manqua pas de provoquer chez elle une vive réaction. Mme Bedford Fenwick, fondatrice et présidente du Conseil International des Infirmières disait ceci: "Lors du prochain Congrès triennal du Conseil International des Infirmières qui se tiendra à Londres en juillet 1909, le Danemark, la Finlande et la Hollande seront admis comme membres, ces pays ayant respectivement complété l'organisation de leur association nationale."

Mlle Snively était une des fondatrices du Conseil International des Infirmières et y occupait même le poste de trésorière honoraire. Au Canada, les infirmières n'étaient pas encore organisées en association nationale et ne pouvaient prétendre au statut accordé à ces pays d'Europe, plus entreprenants.

Cela ne pouvait se passer ainsi! Avec le courage et l'énergie qui caractérisaient sa nature, Mlle Snively convoqua en assemblée les membres du conseil exécutif de L'Association des Directrices des Ecoles d'Infirmières, nouvellement formée. Il fut alors immédiatement décidé d'inviter les directrices des hôpitaux et des écoles d'infirmières du Canada à rencontrer les membres de L'Association des Directrices lors de l'assemblée annuelle afin de considérer l'opportunité de former une association nationale.

De tous les coins du pays l'on répondit avec bienveillance à cette invitation et, le 8 octobre 1908, "dix-huit associations d'infirmières envoyèrent une délégation à Ottawa afin de fonder une société appelée "The Provisional Society of the Canadian National Association of Trained Nurses." Inutile

d'ajouter que Mlle Snively en fut élue présidente.

Parmi les groupes représentés par des infirmières déléguées, deux seulement — l'Association des Infirmières diplômées du Manitoba et celle de l'Ontario — étaient organisées sur une base provinciale. Six groupes se composaient d'infirmières diplômées de diverses écoles, exerçant dans les grandes villes. Sept amicales étaient représentées, venant toutes de l'Ontario.

Sans perdre de temps, l'on sollicita l'admission comme membre du Conseil International des infirmières, ce qui fut accordé avec enthousiasme:

"Le Canada est un des joyaux qui forment la couronne impériale d'Angleterre et ses infirmières ne le cèdent à personne . . . On peut difficilement s'imaginer la chaleureuse bienvenue que l'on fera à cette association du Canada lorsque le Conseil lui prendra maternellement la main et la présentera comme un anneau de la chaine qui unit les infirmières du monde en un groupe international."

Ces paroles étaient de la fondatrice et présidente du Conseil International des Infirmières, ardente impérialiste s'il en fut!

Cinq déléguées de l'Association Nationale furent envoyées au prochain congrès: trois de Toronto et 2 de Montréal. En plus, 20 autres infirmières s'y rendirent d'elles-mêmes — treize de la province de Québec, cinq de l'Ontario et deux intrépides vinrent d'aussi loin que Winnipeg. Durant la réception du Canada comme membre du Conseil International, Mlle Snively fit ce portrait du nursing au Canada:

"Il y a soixante-dix écoles comptant de dix à cent étudiantes et s'étendant de l'Atlantique au Pacifique. L'infirmière d'école a commencé son travail bienfaisant. L'infirmière visiteuse devient chaque année de plus en plus indispensable — elle va porter le soulagement dans les foyers et s'occupe activement des tuberculeux."

Dans un domaine, Mlle Snively fut toutefois forcée d'admettre que peu de progrès avait été accomplis: "Le Canada a essayé à trois reprises, mais en vain, d'obtenir l'enregistrement des infirmières professionnelles; sans se décourager elle n'en espérait pas moins que son voeu serait prochainement réalisé. Une vie fructueuse est souvent une vie de lutte. Ce n'est que par un labeur continu, de durs efforts, une énergie tenace et un courage résolu que l'on peut avancer dans la voie du progrès."

A la fin du discours de Mlle Snively, "les quatre cents infirmières présentes au Congrès se levèrent au son de l'hymne national qui se faisait entendre du corridor."

Une généreuse hospitalité fut offerte aux visiteurs et les déléguées canadiennes eurent même la permission d'aller déposer une couronne de fleurs sur la tombe de la Reine Victoria "privilège qui avait été refusé, deux semaines auparavant, à deux neveux du roi!" A la lumière crue d'aujourd'hui, tout cela ne semble qu'un rêve qui s'efface mais pour celles qui y ont pris part cela a un sens profond. C'était l'âge romantique du nursing!

A la première assemblée générale de l'Association Canadienne tenue en 1911, l'on se rendit compte de la nécessité d'une constitution et de règlements si l'on voulait que l'Association fonctionne efficacement. L'on avait suggéré trois catégories de membres: des associations provinciales, des associations urbaines et des amicales ou associations de diplômées. Un système équitable de votation n'avait pas encore été institué lorsqu'en 1916, l'auteur de cet article fut, pour la première fois, activement mêlée aux affaires de l'Association canadienne. L'Association des Infirmières diplômées du Manitoba était alors en pleins préparatifs pour la première assemblée générale de l'Association Canadienne qui devait se tenir à l'ouest de la frontière de l'Ontario. Toutes les sources d'amusement furent explorées et un comité de réception infatigable se rendit à tous les trains. Il y eut une suite ininterrompue de thés, déjeuners, réceptions, banquets, si bien qu'à la fin de la semaine les dignitaires de l'est étaient visiblement impressionnées pour ne pas dire tout à fait épatées. Du moins c'est ce que nous avons cru.

Malgré les distractions que leur occasionnait leur rôle d'hôtesse, les membres de l'Association des Infirmières diplômées du Manitoba trouvèrent le moyen d'assister aux réunions régulières. La solution au problème de l'incorporation n'avait pas encore été trouvée mais une bonne partie du travail avait été faite à ce sujet. Il fut question de former une section d'hygiène publique. La revue "The Canadian Nurse" devint enfin la propriété de l'Association canadienne. Tout observateur pouvait se rendre compte que la secrétaire honoraire, Jean Isabel Gunn, semblait dépasser toutes les autres. La clarté de sa pensée, sa façon de saisir l'essentiel des principes, son sens de l'humour prouvait qu'elle était un chef digne de ce nom.

Après le départ des visiteurs, l'Association des Infirmières diplômées du Manitoba prit la liberté de se reposer sur ses lauriers. L'on avait su démontrer que le Manitoba occupait

une place importante sur la carte du Canada. Au printemps suivant, lorsque le rapport du comité de nomination nous parvint de l'Est, il ne contenait aucun nom d'infirmière du Manitoba; il y eut un silence absolu jusqu'à ce qu'une voix se fit entendre du fond de la salle, suggérant de nommer tout de même quelqu'un. "Peu importe qui car elle n'a aucune chance d'être choisie." Un membre laissa témérairement soumettre son nom pour la fonction de secrétaire honoraire, simplement en signe de protestation bien sûr, aucune chance d'être élu.

En 1917 l'assemblée générale de l'Association Canadienne eut lieu à Montréal. Les déléguées furent accueillies par Gertrude E. (Nora) Livingston qui depuis 27 ans occupait, avec beaucoup de dignité, le poste de directrice au Montreal General Hospital. Elle consacra la meilleure partie de sa carrière remarquable à édifier l'Ecole d'infirmières réputée dont elle était la directrice. L'histoire révèle qu'elle ne voyageait jamais, n'assistait à aucun congrès ou réunions d'infirmières. Elle réalisait toutefois les bénéfices que l'on pouvait retirer de ces réunions et elle y déléguait toujours des membres de son personnel. A cette occasion, elle vint néanmoins, en personne, vêtue d'une robe de soie noire, coiffée d'un petit chapeau d'allure victorienne, garni d'une touffe de violettes. Bien qu'âgée alors de 70 ans, elle était pleine de vigueur et ses yeux brillants semblaient demander, que faites-vous ici, loin de votre travail? "J'espère que vos malades seront bien soignés durant votre absence" dit Nora Livingston avec un regard railleur.

Une déléguée des provinces des prairies se rappelle encore l'impression qu'elle a eue en voyant pour la première fois le Royal Victoria Hospital dans son site merveilleux, sur le flanc du Mont-Royal ainsi que sa rencontre avec Mlle Mabel Frances Hersey qui fut éventuellement guide, philosophe et amie dans toutes les difficultés et les tribulations que l'on n'entrevoyait pas alors. Les jours s'écoulèrent si agréablement que les Manitobaines avaient tout oublié de leur nomination en guise de protestation, jusqu'au moment des élections. Jean Isabel Gunn fut élue présidente et chaleureusement acclamée. C'est alors que l'événement inattendu se produisit. La préposée de l'est, au poste de secrétaire, retira son nom et aucun autre nom ne fut proposé par l'assistance et, la malchance ne voulut-elle pas que la candidate du Manitoba soit élue, plus ou moins par défaut; on applaudit plutôt machinalement, pour la forme. Elle se retira dans sa chambre, affaissée, pour réfléchir à tout cela. La porte s'ouvrit soudainement et Jean Isabel Gunn entra, tenant sous le bras une énorme serviette dont elle procéda immédiatement à assortir méthodiquement le contenu. "Bien," dit-elle, "il semble que nous ayons été le dindon de la farce, mettons-nous à la besogne." Soudainement il a semblé que Toronto n'était pas si éloigné de Winnipeg, après tout.

Il y avait beaucoup à faire. A la guerre, les choses n'allaient pas très bien et la demande d'infirmières pour le service militaire était si grande que l'on ne pouvait y répondre sans gêner l'action des hôpitaux civils. Il devint évident qu'un plan de coordination des services du nursing devait être formulé et c'est à cette occasion que Mlle Gunn montra son extraordinaire talent d'organisatrice et d'administration. Lentement mais sûrement, les autorités gouvernementales et militaires réalisèrent que cette femme savait de quoi elle parlait et que l'association professionnelle dont elle était présidente constituait une force qu'il fallait reconnaitre. Ce qu'elle a accompli est d'autant plus remarquable si l'on se rappelle que l'Association canadienne disposait de peu de fonds et n'avait ni bureau ni secrétaire rémunérée.

En butte aux mêmes difficultés, l' "American Nurses Association" était dans une bien meilleure position pour les surmonter. Adelaide Nutting, alors à la tête de la section du Nursing et de la Santé au Teachers College, Columbia University, était présidente du Comité National du Nursing des Etats-Unis. Il sembla à propos de l'inviter à titre de conseillère et elle fut la principale conférencière à l'assemblée générale de l'Association des infirmières canadiennes qui eut lieu à l'Université de Toronto. Lorsqu'elle monta sur l'estrade, son émotion était visible. Comme Isabel Hampton, Adelaide Nutting était canadienne de naissance ainsi que par ses ancêtres; elle demeura canadienne de coeur pendant toute la durée de sa longue vie bien qu'elle fut un sujet fidèle à sa patrie d'adoption. Son sens éveillé de l'histoire a dû se reporter sur cette assemblée de Chicago alors qu'était née l' "American Society of Superintendents of Training Schools for Nurses of the United States and Canada." Maintenant, un quart de siècle plus tard, la "Canadian Association of Trained Nurses" qui en était le rejeton, faisait entendre avec autorité la voie des infirmières du Canada. La roue avait fait son tour complet.

Il n'en restait pas moins encore beaucoup à accomplir, particulièrement, obtenir une législation qui permettrait l'enregistrement

dans chaque province. En 1911, l'Association Canadienne des Infirmières diplômées avait posé un beau geste, mais, sans succès, essayant d'obtenir l'enregistrement national en nommant un comité à cette fin. En 1913, le Comité rapporta que :

> Il est d'une importance vitale qu'il y ait uniformité de normes et que la formation et l'enregistrement des infirmières soient le même, en principe, dans toutes les parties du Canada . . . Le plan du comité est de demander à des représentantes de chaque province de préparer la loi qui convient le mieux à cette province. Lorsque tous ces projets de lois auront été préparés, le comité les étudiera, les comparera et, se basant sur les neuf projets de loi, préparera une loi modèle contenant les bons points de chacune.

L'on découvrit que ce problème était beaucoup plus complexe qu'on ne se l'était imaginé ; néanmoins, l'Association canadienne parvint à établir des normes pour les écoles d'infirmières. Les effets de ce programme se firent sentir de façon étonnante à travers tout le pays. Un exemple, entre autres, est la recommandation adoptée par le comité de l'Ecole d'Infirmières du Winnipeg General Hospital : "Que les normes de notre école d'infirmières soient élevées afin de se rapprocher le plus possible de celles établies par l'Association canadienne."

En rétrospective, l'on peut maintenant voir que l'année 1918 a marqué un tournant dans l'histoire de l'Association des Infirmières Canadiennes. Aussitôt la guerre terminée les infirmières virent le public réclamer de plus en plus leurs services, particulièrement en hygiène publique, les demandes furent si insistantes qu'il fut impossible de les ignorer.

Non sans quelqu'hésitation, les universités canadiennes, les unes après les autres, se rendirent à la demande d'organiser des cours pour les institutrices et les surveillantes en nursing. La porte n'était peut-être pas grande ouverte mais elle n'était pas fermée. A ce moment critique, un bon jugement et une action décisive s'imposaient dans notre organisation nationale et l'Association Canadienne des Infirmières Diplômées se montra à la hauteur de la situation.

Qu'est-ce que l'Association a accompli au cours de ce premier cinquantenaire ? Disons qu'en premier lieu beaucoup a été fait pour vaincre la distance qui isolait les unes des autres les provinces de l'ouest et celles de l'est ; des barrières non seulement géographiques mais aussi psychologiques furent ouvertes. Bien qu'il n'y eut pas encore de secrétariat national ni de secrétaire rémunérée, les infirmières canadiennes pouvaient se réunir, échanger des points de vue. Les infirmières ne se comprenaient pas toujours car on n'avait pas encore réalisé que le Canada était ou devait être un pays bilingue. Cela devait venir plus tard.

L'Association s'est aussi libérée de ses tuteurs, (tant américains que britanniques) lesquels, bien que très utiles au début, auraient pu éventuellement entraver notre liberté de penser et d'agir. Déjà l'Association pouvait chercher sa destinée tout en entretenant des relations amicales avec ses amis du sud de la frontière et d'outre-mer. Maintenant il est évident que le champ d'action et la ligne de conduite de l'Association Nationale devront être considérablement élargis si elle doit marcher à la cadence des associations provinciales dont le développement est rapide. Le temps est venu pour l'Association Canadienne de plier ses tentes et de marcher vers de nouveaux horizons.

Tips for Tourists

Attach a flashlight onto the steering post with a bracket or insulation tape.

A collapsible camper's pail is a handy thing for carrying water for the radiator or enough gas to get you to the next filling station.

Wire extra car keys to a convenient bracket under the hood — provided you don't have to release the hood from the dashboard.

Remember that you can insure all your baggage, cameras, etc. for a specific trip.

Don't slump in the seat. Sliding down and sitting on the backbone throws the weight of the body on the hip bones and causes backache.

Don't grip the wheel too tightly and hold the body tense. Tenseness produces nervousness which may prove serious in an emergency.

Don't stare fixedly ahead. Get the eyes accustomed to an easy, restful position.

— *Blue Print for Health*

Consider the postage stamp, my son. It secures success through its ability to stick to one thing till it gets there. — Josh Billings

The most effective long range missile is the virus which gave us the Asiatic Flu.

— *Hospitals*

Changes in the Patterns of Nursing

E. Kathleen Russell, B.A., B.Paed., D.C.L., Ll.D.

"Plus ça change, plus c'est la même chose." Thus runs the old French adage which, being interpreted freely, says that the more we change, the more we remain the same. Of nothing could this be more true than as a description of the progress of nursing in the past half century. There have been great changes in nursing affairs and yet a great sameness persists. Can we explain this paradox?

As we look back to the year 1908 we see our founders as a small group of women scattered in a few urban centres, with little power or prestige, either socially or politically, but endowed with unusual courage and wisdom. They met within that year in order to form a national association of Canadian nurses and they accomplished their purpose. Thus, the Canadian Nurses' Association was born. It seems that there must have been at that time a christening party of the old fairy-tale type with benevolent godmothers bestowing many good gifts on the newborn infant, but with one wicked fairy casting an evil spell. Endowed with its good gifts, our Association has grown in size and strength and has enabled Canadian nursing to expand its services widely. Yet, the evil spell persists and all results are conditioned thereby. Our hope is to explain this and thus to help present efforts to break the spell. The evil spell itself was *the saddling of hospitals with the total responsibility for nursing schools, and the encumbering of our schools with responsibility for hospital service.*

E. Kathleen Russell

Let us turn now from fairy-tale imagery to hard facts, hoping thereby to make these facts better known and comprehended.

To understand the development of nursing in these past 50 years, we must place it against a backdrop of the social and medical history of the period. But first the period itself demands special attention. The precise years of our Association's life-span date from 1908 to this present year of 1958. We wonder if there has been any 50-year period in the history of the world that can be compared with this, so full of toil and trouble, of excitement and development in every field of human interest and endeavor, and of vast social upheavals including the horrors of two world wars. We know what these wars have done to create a seething world community in which men of every creed and color are struggling to learn how to live with their neighbors of other nations. And these same wars have precipitated medical, hospital and nursing developments at a pace far beyond that of any previous time.

First, we see that following rapid scientific advances, medical knowledge and medical practice have progressed at an unprecedented rate. When the Canadian Nurses' Association was organized in 1908, the 20th century research laboratories were just being formed; bacteriology and immunology were sciences so new that some of the older medical practitioners had not known them in medical school; all radiation work was in its infancy,

Miss Russell was formerly director of the School of Nursing, University of Toronto. She resides in Toronto.

while surgery, internal medicine and diagnostic methods were starting upon an almost feverish expansion. Up to that time, no national government had had a ministry of health. Hospitals were relatively few in number and restricted in the services which they offered.

A startling thought for nursing is that it was very close to this same time that a drastic change took place on this continent in the whole face of medical education. Following the exposures forced by Dr. Abraham Flexner's work and his famous Report on the subject, irresponsible medical schools were closed and the exploitation of medical students was terminated once and for all. Unfortunately, no Dr. Flexner appeared to champion the cause of appropriate nursing schools.

In this same 50 year period, social thought and practice have progressed rapidly. During the previous century (i.e. the 19th), influences had been at work to fix attention upon the needs of the weakest groups in society. Reforms had been instituted in many fields but, except in the minds of a few leaders, there was not even a vision of the welfare state with legislation to bring greater social security for all classes and conditions of people, the sick, the poor, the children, the afflicted, the unemployed, the aged, etc. This social development is very recent. The Canadian Nurses' Association was already three years of age when — in 1911 — David Lloyd George presented his Medical Insurance Bill to the British Parliament, the bill that was to be followed by so much social legislation in England and subsequently in Canada. It is of this bill that the biographer, Frank Owen, says "If Lloyd George's reputation as a social builder . . . had to rest upon the National Insurance Act of 1911 alone, it would still be secure. For this Act set the mould, and it built the base for all the other acts of social reform which have led our people forward since then toward the concept of the Welfare State."[1]

The most important point for our present argument is that every step in this medical and social development has laid further demands upon nursing. This jubilee year finds the CNA facing a tremendous task. First, there is need for a vastly wider range of nursing service in the curative field, both in the hospital and in the home. To some readers it may seem unnecessary to labor the point regarding the expansion in hospital services during the past 50 years. But, do we indeed realize it? Consider the daily routine of the hospital nurse in 1908; in actual fact she was extremely busy and she carried the same heavy responsibility, as at present, of life or death for her patients, depending upon her own powers of observation, integrity, humanity and intelligence. But it is necessary to go much further in marking the comparison between the nursing service of the two periods. With the insistent demand for the same personal qualities as hitherto, we must recognize the need today for a vastly heavier detail of knowledge and understanding from the nurse. In the interval, the physician has laid upon the nurse a share of his former duties. And the development in medical practice, with the consequent pressure on hospitals, has given the nurse a larger number of acutely ill patients; and has given her also the need to be ready to understand and cooperate in treatments and medications entirely unknown at the beginning of the century. Also, there are new types of hospitals and of hospital services which have accumulated with great rapidity.

All of this has complicated the problem of nursing education. First, we must have in Canada a huge group prepared to perform safely the routine duties of bedside care. In addition, there must be others ready for far more than the routine in bedside care, that is, highly specialized work of many kinds. And finally, we must have an officer corps ready for teaching, supervision, administration and research. All of this is required for curative work alone, while public health preparation is adding its own special demands upon the educational field.

Now, the demand for nursing in the home has become more prominent rather suddenly, especially so in view of the coming health insurance plans. As hospital beds must be reserved for the work that can be accomplished only there, so there is developing an increase in the number of sick who must be nursed at home. The visiting nursing associations can do a vast amount in

the localities where they function, but this is restricted to the patients — and they are many — who can be served safely by part-time care. In addition, there are many in their own homes who should have continuous nursing throughout the 24 hours, at least for the period of acute illness. This continuity of care is often the very essence of the nurse-patient relationship, and the basis of satisfaction and success in the nurse-physician relationship. Surely the day will come soon when we shall have home nursing service established as certainly as hospital service, with the extensive organization that can be provided only by public authority. It is just as unrealistic to expect the nursing profession to organize home nursing services for the whole of Canada — urban and rural areas alike — as it would be to expect nurses to build the hospitals. Continuous care should be available when needed, and nursing staff should be on salary. We must expect something of this type to follow on the heels of health insurance. Hospital beds cannot be extended indefinitely but nursing care must be forthcoming. In this connection we appreciate the thought expressed recently in an address by the Deputy Minister of Health, Dr. Donald Cameron.

> It is in a way laboring the obvious to point out that hospitals are a very different kind of institution than they were 50 years ago. From benevolent charitable shelters for those of modest resources and in destitute circumstances, they have become, in our time, something very much closer to public utilities ... I do hope, however, that we will not swing from the extreme of treating only a very small range of conditions in hospitals of a generation ago to the opposite extreme of treating nearly every case of illness in hospital ... The whole field of home care and chronic care represents a tremendous challenge.[2]

As nursing in the curative field increases, so it is, and will be, in preventive medicine, for nothing can stop the developments in public health work. The CNA understands this and for nearly forty years has tried to build suitable preparation for public health nursing. At first this necessitated the effort to place a superstructure on weak and uncertain foundations; and also the need to change the nurses' interest from cure alone to prevention and cure. In forty years much has been accomplished but our Association recognizes that a serious educational problem lies ahead if we are to share worthily in this activity.

May we repeat in summary that readiness for both curative and preventive service carries us back to nursing education. All professional work will be just as good as its schools. Here lies the problem. We ourselves as nurse, and also our medical colleagues, need to realize fully the sudden and tremendous expansion that has been forced upon nursing in this century alone, and to realize at the same time that our efforts toward development have been frustrated by the utter folly of clinging to outdated organization for hospital nursing practice and for nursing education — the evil spell that the wicked fairy cast upon us. Already there has been a notable effort toward deliverance from out-moded forms of nursing education. The past few years have been marked by understanding and courageous effort on the part of the nursing profession but now there is desperate need for help from the community at large, from governmental authorities and from the medical profession. For our encouragement, this writer likes to quote from a deeply thoughtful and authorative medical writer, namely, Professor Brotherston of the Department of Preventive Medicine of the University of Edinburgh. Two years ago Prof. Brotherston was taking part in an international conference on nursing education and spoke as follows:

> I know of no other profession at the present time which is prepared to do so much heart searching about its future as nursing. It is true that the stimulus has been a crisis — a crisis of recruitment. But response to stimulus is the sign of life. The response of the nursing profession shows abounding life. Perhaps you should really be grateful for your crisis which has stimulated so much self-criticism and re-thinking. I am sure that, however, complaisance is the last thing you want me to express. Indeed there is no room for it. For although there is the ferment of a Renaissance in

the nursing profession, the situation in which you have to live, breathe and grow up remains virtually unchanged. This week we have been discussing the ideas of 1956, but the framework in which you are asked to cultivate them survives from 1856. The greatest problem, therefore, in terms of changing needs is this conflict between new ideas and an out-moded environment in which you have to bring them into being.

There is one further "change" that has become very perplexing for our Association as it finishes the first half century. This again is the direct result of the vast increase in nursing activities: we refer to the division of work between the registered nurses and the assisting groups. The problem of too much work has brought the new problem of a very great variety of work, some of which requires much more of educational preparation than the rest. The medical profession has met a similar situation by sharing its work with various groups of technicians but nursing cannot find a solution so easily. The Canadian Nurses' Association will have to struggle long and hard before it works through this problem.

So, we started to write about our 50 years under this title of "Changes in the Patterns of Nursing." Are we indeed to have "change" or are we to continue with "la même chose," shackled by out-dated patterns, particularly in our schools? At the approach to this jubilee year (that is, in November, 1957) our Association held its first all-Canadian Conference on Nursing. The keynote sounded there was the demand for certain appropriate changes. We may hope to build on, and from, that conference for the work that lies ahead in the coming half century. Is it possible that the November Conference has broken the spell of the wicked fairy, and that nursing will be permitted to come alive in all the beauty of adequate education for adequate service?

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1. "Tempestuous Journey" by Frank Owen, page 206.
2. Federal Hospital Insurance Proposals: *The Canadian Hospital*, July 1957, page 70.

Changements en Nursing

E. Kathleen Russell, B.A., B. Paed. D.C.L., Ll.D.

"Plus ça change, plus c'est la même chose."

Ce vieil adage peut très bien s'appliquer à la description que l'on pourrait faire des progrès du nursing depuis un demi-siècle. Il y a eu de grands changements dans le nursing et pourtant que d'aspects sont restés les mêmes! Pouvons-nous expliquer ce paradoxe?

Jetons un regard sur le passé! Reportons-nous à l'année 1908 et observons un moment les fondatrices de l'Association des Infirmières Canadiennes: un petit groupe de femmes dispersées dans quelques centres urbains, à peu près sans pouvoir ou sans prestige social ou politique mais, dotées d'un rare courage et de beaucoup de sagesse. C'est durant cette année, devenue mémorable, qu'elles se sont réunies pour former une association nationale d'infirmières; leur projet était réalisé. L'Association des Infirmières Canadiennes était née. Comme dans les contes de fées, quelques bonnes marraines ont dû présider à sa naissance et doter de nombreux dons le nouveau-né. Mais, n'y avait-il pas aussi une mauvaise fée qui guettait, dans l'ombre, le moment de jeter ses sorts! Grâce aux dons reçus de la bonne fée, notre Association a grandi, s'est développée, est devenue forte et a su donner au nursing canadien l'envergure que nous lui connaissons aujourd'hui. La mauvaise fée a aussi fait son oeuvre obscure; souvent elle est venu entraver ou ralentir nos élans. Nous voulons donc, de notre mieux, vous expliquer la situation et, avec votre concours, conjurer le mauvais sort. Quel est-il ce mauvais sort? N'est-ce pas lui qui a chargé les hôpitaux du lourd fardeau de l'entière responsabilité des écoles d'infirmières puis qui a imposé à nos écoles la responsabilité du service hospitalier?

Abandonnons les contes de fées pour la réalité espérant, par l'exposé des faits, les faire

mieux connaître et plus facilement comprendre.

Pour bien comprendre l'évolution du nursing depuis 50 ans, nous devons placer en contexte l'histoire sociale et médicale de cette période. Disons, en premier lieu, que c'est une période qui retient grandement l'attention. 1908-1958! La première partie du règne de notre Association nationale. Nous nous demandons si, dans l'histoire du monde, une autre période de cinquante années peut se comparer à celle-là, remplie de labeurs, d'épreuves, d'agitation et d'innovation dans tous les domaines de l'activité humaine sans parler du bouleversement social apporté par deux grandes guerres mondiales. Nous savons comment ces deux guerres ont amené le monde à un état d'effervescence, chacun, qu'elle que soit sa race ou sa croyance, se débattant, luttant, essayant d'apprendre à vivre avec son voisin et avec les autres nations. Ces mêmes guerres ont fait évoluer la médecine, les hôpitaux et le nursing à un rythme jamais connu jusque-là.

D'abord nous constatons qu'à la suite des progrès de la science, les connaissances et la pratique de la médecine ont évolué à une allure sans précédent. Lorsque l'Association des Infirmières Canadiennes fut fondée, en 1908, les premiers laboratoires de recherches venaient à peine de faire leur apparition; la microbiologie et l'immunisation étaient des sciences si nouvelles que certains vieux médecins n'en avaient jamais entendu parler dans leurs écoles de médecine; la radiologie en était à sa première enfance; la chirurgie, la pathologie et les méthodes de diagnostic prenaient un essor vertigineux. A cette époque, aucun gouvernement ne possédait un ministère de la santé. Les hôpitaux étaient peu nombreux et leurs services limités.

Un événement qui peut faire réfléchir les infirmières se produisit vers ce temps, ce fut le changement drastique qui se fit dans l'éducation des médecins, à la suite des travaux et du fameux rapport du Dr. Abraham Flexner. Les écoles de médecine sans valeur furent définitivement fermées et les étudiants en médecine cessèrent d'être exploités. Malheureusement, il n'y eut aucun Dr. Flexner pour se faire le champion de la cause des écoles d'infirmières.

Au cours de cette même période de 50 ans, la pensée et l'action se sont orientées du côté social et de grands progrès furent accomplis dans ce domaine. Durant les siècles précédents, notamment le 19ième, l'on s'était efforcé d'attirer l'attention sur les besoins des groupes les plus faibles, les moins favorisés de la société. Des réformes avaient été apportées dans bien des domaines, mais sauf dans l'esprit de quelques chefs, l'on ne pouvait imaginer alors un état de bien-être s'appuyant sur des lois et pouvant assurer une assistance à toutes les classes de la société: malades, pauvres, enfants, infirmes, chômeurs, vieillards, etc. Cette sécurité sociale est de date récente. L'Association des Infirmières Canadiennes existait depuis trois ans lorsqu'en 1911, David Lloyd George présenta au Parlement britannique son projet de loi: assurance-maladie, loi qui fut suivie par toute une législation sociale en Angleterre et, plus tard, au Canada. C'est au sujet de cette loi que le biographe du fameux ministre, Frank Owen écrivit: "Si la réputation de Lloyd George comme promoteur social ne reposait que sur cette loi nationale d'assurance-maladie de 1911, elle serait encore bien solide. Cette loi a été le modèle et la base de toutes les autres réformes sociales qui ont fait avancer notre peuple vers le concept du 'Bien-Etre Social.'"[1]

Le point très important de cet argument et que nous tenons à souligner, c'est que chaque pas fait dans la voie du progrès social et médical crée de nouvelles demandes au service d'infirmières. Durant cette année jubilaire, l'A.I.C. aura à faire face à une tâche immense. En premier lieu, le besoin s'impose d'une plus grande variété de services pour répondre au soin des malades dans les hôpitaux et à domicile. A quelques lecteurs, il peut sembler inutile que nous nous arrêtions à exposer le développement des hôpitaux depuis 50 ans. Mais nous-mêmes, nous rendons-nous vraiment compte de cette évolution?

Considérons le travail de l'infirmière en 1908; elle était très occupée et avait à s'acquitter des mêmes grandes responsabilités que l'infirmière de nos jours: la vie ou la mort de ses malades dépendant de son sens d'observation, de son intégrité, de sa bonté et de son intelligence. Mais il est nécessaire d'aller plus avant dans la comparaison du soin des malades de ces deux époques. Nous devons reconnaître que si les qualités personnelles de l'infirmière demeurent absolument les mêmes, elle a besoin aujourd'hui de connaissances beaucoup plus étendues et d'une plus grande somme de compréhension. Depuis ce temps, le médecin a, peu à peu, confié à l'infirmière des tâches qui étaient autrefois de son domaine. Les progrès de la médecine et par le fait même un service hospitalier beaucoup plus intense font que l'infirmière a un plus grand nombre de cas de maladies graves à soigner et qu'elle doit

être préparée à coopérer à l'administration de traitements et de médicaments qui étaient totalement inconnus au début du siècle. En plus, des hôpitaux et des services de nouveaux genres se sont accrus rapidement.

Tout cela vient compliquer le problème de l'éducation de l'infirmière. Disons d'abord que nous avons besoin, au Canada, des services d'un groupe nombreux de personnes préparées à donner avec sécurité les soins de routine au chevet du malade. Il nous faut aussi les services d'un autre groupe de personnes possédant plus que les capacités de donner les soins de routine et pouvant en outre exécuter, dans bien des domaines, certaines fonctions particulières, ce que l'on pourrait appeler un travail spécialisé. Enfin, il nous faut un groupe dirigeant, constituant les cadres du nursing, se destinant à l'enseignement, la surveillance, l'administration et la recherche. Tout ce monde est nécessaire à la seule fin de donner des soins aux malades; en plus l'hygiène publique réclame à l'éducation la part qui lui est nécessaire pour la formation de son propre groupe.

Le soin des malades à domicile est devenu soudainement impérieux, particulièrement en vue des programmes futurs des assurances-santé. Les lits d'hôpitaux devant être réservés aux cas qui ne peuvent être traités ailleurs, il s'ensuit qu'un grand nombre de malades devront être soignés à la maison. Les sociétés d'infirmières visiteuses peuvent faire en grande partie ce travail dans les villes où elles sont établies mais leurs services ne s'adressent qu'aux malades qui peuvent se contenter de soins à temps partiel, et, certes, il y en a un grand nombre. Mais, combien d'autres malades, dans leurs foyers, ont besoin de soins 24 heures par jour, du moins pendant la période aiguë de leur maladie. Cette continuité de soins est souvent l'essence même des relations infirmière-malade et la base du succès et de la satisfaction des relations médecin-infirmière. Le jour n'est pas éloigné où nous aurons besoin d'un service de soins à domicile aussi bien établi que le service hospitalier et dont le développement ne peut être assuré que par l'autorité publique. Il ne serait pas plus raisonnable de s'attendre à ce que les infirmières organisent le service du nursing à domicile dans tout le Canada — dans les villes comme dans les centres ruraux — que de les voir construire des hôpitaux. L'on devrait pouvoir se procurer, en cas de besoin, des soins continus et les infirmières à cette fin devraient recevoir un salaire. Nous pouvons nous attendre à l'établissement d'un service de ce genre, une fois les assurances-santé établies. Les lits d'hôpitaux ne peuvent se multiplier à l'infini mais les soins aux malades devraient toujours être disponibles. A ce sujet, nous apprécions à sa juste valeur la pensée exprimée par le sous-ministre de la Santé Nationale, le Dr. Donald Cameron.

> C'est répéter un fait connu de tous, de dire que l'hôpital d'aujourd'hui est bien différent de celui d'autrefois, d'il y a 50 ans. D'institutions charitables abritant les pauvres et les malheureux, qu'ils étaient les hôpitaux sont devenus presque des services publics . . . J'espère, toutefois, que nous n'irons pas d'un extrême à l'autre: de celui de ne traiter à l'hôpital que quelques catégories de malades, comme on le faisait autrefois, à celui d'y admettre tous ceux qui se sentent malades. C'est ici que se révèle l'ampleur des soins que réclameront les malades à domicile et les malades chroniques.[2]

La médecine curative exige toujours davantage du service du nursing; ainsi en est-il et continuera de l'être de la médecine préventive car, rien ne peut arrêter le développement de l'hygiène publique. L'A.I.C. l'a compris et c'est pourquoi, depuis plus de 40 ans, elle s'est efforcée d'établir une préparation convenable au nursing en hygiène publique. Au début, cela a demandé un effort; il s'agissait d'étayer, de consolider des bases qui ne semblaient pas trop solides et aussi, de diriger l'intérêt de l'infirmière, alors uniquement porté vers l'aspect curatif du nursing, vers celui de la prévention. En quarante ans, nous avons accompli bien des choses mais notre Association reconnaît que nous aurons à envisager un grave problème d'éducation si nous voulons, dans l'avenir, dignement participer à cette activité.

En résumé, nous pouvons dire que notre désir d'assurer les soins curatifs et préventifs nous ramène à l'éducation des infirmières. La valeur de tout travail professionnel se mesure à la qualité de ses écoles. Nous, infirmières, tout comme les médecins, avons besoin de réaliser dans toute son ampleur le développement formidable et soudain dont a été l'objet la profession d'infirmière depuis le début du siècle et aussi que nos efforts vers le progrès ont souvent été frustrés par l'attachement à des organisations désuètes dans la pratique du nursing et dans l'éducation des infirmières — le mauvais sort que nous a jeté la vilaine fée! Déjà des efforts appréciables ont été faits pour débarrasser l'enseignement du nursing de formules démodées. Ces dernières années ont été marquées par la compréhension et les courageux efforts de la profession d'infirmières mais

maintenant ce qu'il faut c'est le concours du public, des autorités gouvernementales et de la profession médicale. Pour notre encouragement, l'auteur de cet article se fait un plaisir de citer les paroles d'un médecin, écrivain réputé et penseur profond, le professeur Brotherston de la Division de la Médecine Préventive de l'Université d'Edinburgh. Il y a deux ans, le professeur Brotherston, participant à une conférence internationale sur l'éducation de l'infirmière, s'exprimait ainsi:

> Je ne connais actuellement aucune autre profession qui ait tant à coeur de connaître son avenir, que celle des infirmières. Il est vrai de dire que le stimulus a été une crise — une crise de recrutement. Toute réaction au stimulus est un signe de vie. La réaction de la profession d'infirmière démontre sa vitalité. Peut-être avez-vous raison d'être reconnaissantes de cette crise qui vous a permis de vous critiquer vous-mêmes et de réfléchir. Je suis convaincu que vous ne désirez pas recevoir des compliments. En vérité, ce n'en est pas le moment, car, bien qu'il y ait dans votre profession un ferment de renaissance, la situation dans laquelle vous êtes appelées à vivre, à vous développer, demeure virtuellement la même. Cette semaine, nous avons discuté sur des idées émises en 1956 mais les cadres dans lesquels elles doivent évoluer datent de 1856. Le grand problème est donc de répondre à des besoins nouveaux; n'y a-t-il pas conflit entre les idées actuelles et le milieu désuet dans lequel vous devez les faire évoluer.

Il y a un autre changement qui rend notre Association perplexe au terme de cette première moitié de siècle. Il s'agit toujours de la conséquence directe de la vaste augmentation des activités dans le domaine du nursing. Nous voulons parler de la répartition du travail entre les infirmières et les groupes auxiliaires. Le problème du surcroit de travail en a amené un nouveau, celui de la grande variété des tâches dont certaines exigent une préparation plus approfondie que d'autres. La profession médicale a trouvé une solution à un problème identique en partageant son travail avec un groupe de techniciens, mais la solution n'est pas aussi facile pour les infirmières. L'Association des Infirmières Canadiennes aura à lutter avec ardeur et constance pour résoudre ce problème.

Au début de cet article, nous avons voulu l'intituler "Changements en Nursing." Allons-nous véritablement avoir des changements ou, continuerons-nous de la même façon, trainant comme un boulet des formules démodées, tout particulièrement dans la question de nos écoles! A l'approche de notre Jubilé d'Or notre Association a tenu sa première conférence nationale sur le nursing. L'accent fut mis sur certains changements jugés opportuns; nous pouvons espérer, à la suite de cette conférence, édifier, au cours du demi-siècle à venir, l'oeuvre qui nous attend. Espérons que le mauvais sort aura été conjuré au cours de cette conférence de novembre 1957 et qu'il soit permis aux infirmières de revivre dans toute la beauté qu'offre une solide éducation pour la réalisation d'un service de tout premier ordre.

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1. "Tempestuous Journey" par Frank Owen, page 206.
2. "Federal Hospital Insurance Proposals:" *Canadian Hospital Journal*, juin 1957, page 70.

A new five-cent postage stamp is being issued on July 30, 1958 to emphasize the importance of health both to the individual and to the nation. The slogan "Health Guards the Nation" conveys this theme. The portrait of the nurse on the stamp will remind Canadians of the devoted women whose lives have contributed so greatly to building the welfare of the Canadian nation.

The stamp was designed by Gerald Trottier, Ottawa, who also designed the recently issued La Verendrye and Quebec anniversary commemorative stamps. The designer was born in Ottawa, attended the Art Student's League in New York in 1953 and studied in Europe on a Canadian Foundation scholarship. He has a studio in Ottawa where he works as a painter and graphic artist.

The National Health stamp will be of medium size, approximately one and one-eighth inches high by one and a half inches wide.

Medical Practice in the Last Fifty Years

DONALD S. FLEMING, M.D., D.P.H.

THE MEDICAL PROFESSION is only one of the many established professional groups in our culture, but in no other does the element of service to the public rank higher. The art and science of medical practice has its basis in the need of the population for medical care. It is the ability to provide effective services of many kinds that is the yardstick by which one must judge progress in medical practice.

Since medical practice involves the application of scientific knowledge to problems of health, it is all too easy to give undue prominence to the phenomenal growth of medical science in all its branches during the past half century and to fail to realize that it is only by the application of these advances to the individual, the family and the community that medical practice has any claim for recognition as a progressive element in modern life.

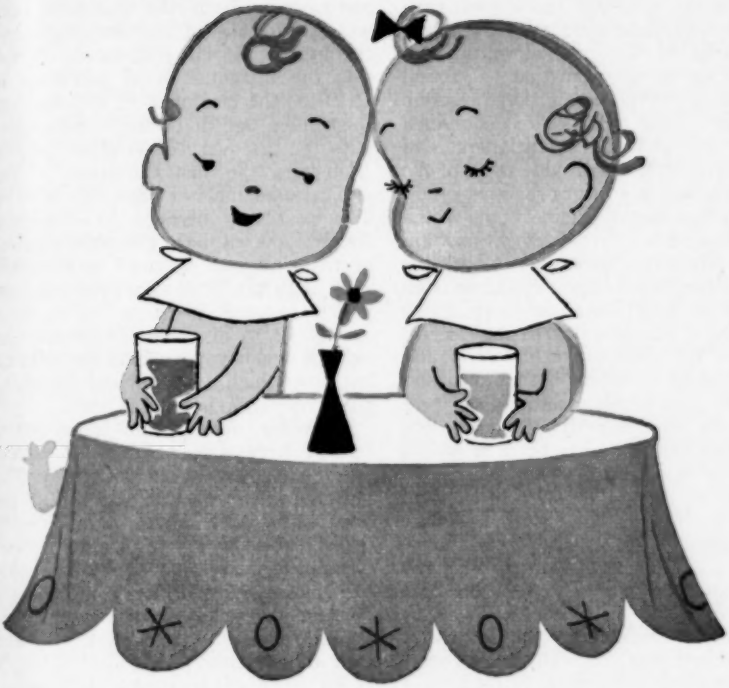
In that the medical profession works with and among people, the manner of medical practice has been markedly affected by all of the social, economic and other changes experienced by our population in the 20th century. Many of these important changes, which have had a direct influence upon medical practice, have been entirely beyond the control of the profession and thus medicine has simply moved with changing times. The growth of our numbers, the rise of urban centres and a large industrial population, the catalytic effect of two world wars in speeding up the process of change, technological progress especially in communication and transportation, and the improved standard of living of the great mass of our people have all combined to create new demands upon the medical practitioner and the necessity for change in the methods of medical practice to meet these needs.

The family unit of the mid-century is often smaller, is certainly more mobile and with less established roots, than was the case with its predecessors. In consequence, the importance of the general practitioner as the primary source of medical care has diminished since his function as a family doctor demands time and stability in the families served. This tendency, together with advances in medical science, has greatly encouraged the growth of specialists in medical practice. There are now fewer full-time general practitioners than in the past.

While it is true that general practice is often regarded as the best preparation for effective practice of a medical specialty, this path is rarely trodden. The specialist has received increasing recognition, both from his colleagues and the public, and the establishment of the Royal College of Physicians and Surgeons of Canada in 1929 provided an effective means for assessment of those seeking specialist status in this country. However, since the general practitioner is judged to be competent to take care of 85 per cent of the illnesses to which patients are liable, it is obvious that the great bulk of medical service should be provided by this element of the profession. The past several years have seen an organized effort to improve the professional status of the general practitioner and the establishment of the Canadian College of General practice is evidence of substantial progress toward this goal.

The clinical training of the future physician is offered in a hospital setting and the advances in scientific methods for diagnosis and treatment often require facilities that can only be found in a hospital. This need for greater hospital facilities has been recognized both by individuals and governments and the tremendous increase in hospitals has resulted in a much more hospital-centred medical practice than a half-century ago. The modern graduate in medicine is unwilling to attempt practice without such resources, but fortunately the development of modern

Dr. Fleming is Associate Professor of Health and Social Medicine, McGill University, Montreal, Quebec.



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transportation permits this in all but isolated areas.

Since the specialist has a great contribution to make in meeting the medical needs of the population, an approach to the problem that has found increasing acceptance is that of group practice. This allows for combined effort by general practitioners and specialists and can provide most of the technical and laboratory services essential in modern medicine. One could hope that such an arrangement may aid the family physician to re-establish his former position, because medicine is an individual actvity even when practised in groups. There is increasing acceptance of the importance of family and social environment in both health and disease. The family doctor is the best equipped to assess these factors, but too often this task has been delegated to the medical social worker.

Changes in the manner of medical practice during the past fifty years have been accompanied by even more striking advances in the ability of the physician to render effective care. Compared with the present, the scientific basis for medical practice in the past was indeed meagre both in diagnosis and treatment of illness. For effective treatment there must first of all be an accurate diagnosis and therefore progress in this latter element of medical practice deserves first consideration.

In the early years of this century, the infections were the leading causes of death and ravages of communicable diseases were largely unchecked. The period since then has been rich in advances of understanding of the nature and recognition of the etiological factors and their means of spread in infectious diseases. There has also been a striking advance in our knowledge of degenerative diseases, of neoplasms, of nutritional diseases, and disorders of metabolism. With acquisition of this basic knowledge as to the nature of disease, there has also been a corresponding advance in diagnostic techniques. Thus there has occurred such useful additions as the Wassermann test, the electrocardiograph, the developments of radiology and radioactive materials and a host of chemical and other tests.

With increased accuracy in diagnosis, there has also been a corresponding advance in many fields of therapy. The most striking development has undoubtedly been the discovery and widespread use of chemotherapy and the antibiotics. The first major success was the introduction of salvarsan in 1910 for the treatment of syphilis, but the golden age of chemotherapy came with the discovery of sulphanilimid in 1936 and the demonstration of the clinical usefulness of penicillin in 1938. The past two decades have been a steady flow of new chemotherapeutic agents designed to meet new needs, such as to handle those microorganisms which become resistant to existing agents, or to discover agents effective against organisms, such as the tubercle bacillus, which were not susceptible to the early methods of treatment.

However, advances in treatment of disease have not been limited to the spectacular field of chemotherapy. The period under review has provided the opportunity to eliminate the deficiency diseases; to use whole blood and fractions of it to great advantage; to apply the knowledge now existing concerning the metabolism of water and electrolytes and the significance of nutrition in health and disease.

An area of treatment in medical practice to which Canada has made a notable contribution has been in respect to those conditions in which hormonal factors are important. The discovery of thyroxin in 1914 directed attention to the significance of the glands of internal secretion; but it was the isolation of insulin in 1922 by Banting and Best, which provided a means of effective treatment for diabetes mellitus, that placed in the hands of the medical practitioner the first of many useful hormonal preparations for application on a wide scale. More recently the production of cortisone has given hope that an effective measure of treatment for rheumatoid arthritis has been made available.

Possibly the following comparison will indicate most clearly the advances in treatment procedures of medical practice. In 1910, according to Keefer, the ten most important drugs in medical practice were:

(1) ether, (2) morphine, (3) digitalis, (4) diphtheria antitoxin, (5) smallpox vaccine, (6) iron, (7) quinine, (8) iodine, (9) alcohol, (10) mercury.

A similar list compiled by Fishbein in 1945 reveals the chemotherapeutic revolution in full bloom:

(1) penicillin, the sulfas and antibiotics, (2) whole blood, blood plasma and blood derivatives, (3) quinacrine and other antimalarial synthetics, (4) ether and other anesthetics, (5) digitalis, (6) arsphenamines, (7) immunizing agents, (8) insulin and liver extract, (9) hormones, (10) vitamins.

Advances in the ten years since this listing have been rapid and thus we must add:

new antibiotics; cortisone and ACTH; anticoagulants like heparin and dicumarol; morphine substitutes like methadon; folic acid; antihistamines; and the tranquillizers.

The physician of today has at his disposal techniques for diagnosis and materials for treatment that create a great gulf between him and his predecessor of half a century ago. However, not only have the technical procedures of medicine changed; there has been almost as great a change in the needs of the public for medical care, since success in some areas has created new problems in others or has at least made older needs more evident.

In the early years of the century, the rank order of principal causes of death was:

(1) tuberculosis, (2) pneumonia, (3) diarrhea and enteritis, (4) heart disease, (5) diseases of infancy and malformation.

By the mid-century, the rank order for Canada was:

(1) heart disease, (2) cancers, (3) diseases of early infancy, (4) accidents, (5) respiratory tract infections.

This striking change in mortality, with heart disease now accounting for about one-half of all deaths, with tumors accounting for one-sixth, and with accidents and the diseases of early infancy each accounting for one-twelfth, is evidence that the problems of medicine have been altered through either the elimination or great reduction of infections and other communicable diseases or have been given a new emphasis in the increased importance of the degenerative conditions, accidents, and an aging population.

In reduction of both morbidity and mortality the most striking advance of medical practice has been in the control of infectious diseases. This has involved both prophylaxis and effective treatment in some conditions. In the case of the communicable diseases it has been possible to develop effective procedures of immunization as well, so that diphtheria, as an example, has virtually disappeared. While others of the communicable diseases persist, they are either on a much reduced scale, as in the case of the enteric fevers, or at least the mortality formerly associated with them has declined, as is seen in respect to pertussis and measles. Then too, increased knowledge of these diseases has allowed measures of control such as isolation and quarantine to be applied on a more realistic basis, so that many burdenss formerly carried by the medical practitioner in connection with the communicable diseases have vanished or been appreciably lightened.

The lessening of the burden of acute, too often fatal, illness in medical practice has at last afforded the medical practitioner a chance to broaden the scope of medical practice to include preventive and rehabilitative aspects as well as those of diagnosis and treatment. One would not wish to overemphasize progress in this regard, but it is true that increased knowledge has led to a widespread application of preventive medicine in many areas of practice — immunizations, regular medical supervision of pregnant women, infants, adults in industry, as examples — and successess of these endeavors do encourage their gradual extension. Similarly, the aging of the population and the better results of treatment for many conditions have forced the medical practitioner to accept the point of view that maximum rehabilitation of the patient is a critical element in the treatment of disease even if complete recovery of function cannot be anticipated.

The people of Canada have benefitted to a marked degree from advances in medical practice during the past fifty years. Without question the standard of medical care is at a higher level han ever before achieved. Such care is costly, but it is the need and demands for other things than the physician's services that are the greatest element in this increased cost.

Since we accept the principle that

every citizen should have the opportunity to benefit from the advances of medical science, it is obvious that programs must be developed to meet this need. Such a planned approach to the problem of medical care will undoubtedly have a marked effect upon medical practice. It is a safe prediction that the efforts to resolve our present problems in meeting the wishes of all to benefit from what medicine can offer will be the major factor in the progress of medical practice during the next half century.

Fifty Years of Progress in Surgery and Anesthesia

HAROLD R. GRIFFITH, M.D., F.R.C.P. (C)

FIFTY YEARS AGO surgeons repaired hernias, removed appendices, drained gall bladders, opened abscesses, reduced fractures, took out cataracts, sliced off tonsils, and hammered away at mastoids. Most of the patients who underwent operations eventually recovered, but whole areas of the body in which surgical intervention is now commonplace were then quite inaccessible. Postoperative care involved long periods of absolute immobility accompanied by a weird assortment of enemas, gavages, douches and infusion.

My first personal experience with operations was in 1907 when I had an appendicectomy. My most vivid recollections of that adventure are of kindness of the nurses who looked after me, and of the extremely unpleasant ether with which I was nearly smothered by the anesthetist. I am glad to be able to look back now on a professional career of many years, in which I have seen not only continuing kindness but increasing skill and efficiency among my nursing colleagues and in which, also, I have had some share in taking the fear and most of the danger out of anesthesia.

Today, surgeons delve into the brain, the lungs and the heart, into arteries, kidneys, and liver. They perform fantastically difficult and complicated operations upon the bowel and other organs. They operate on newborn babies and on feeble octogenarians with the nonchalance which used to be reserved only for robust youth. What has brought about, in 50 years, such a revolution in surgery? There have been many contributing factors — better hospitals and equipment, better trained surgeons and better qualified nurses. In my opinion, however, the specific developments which have made modern surgery possible could be listed as follows:

BIOCHEMICAL APPROACH

The extension of our knowledge of biochemistry and physiology and the application of this knowledge to clinical practice has led to an understanding of fluid and electrolyte balance, and endocrine function; and to an appreciation of the rôle of the autonomic nervous system.

BLOOD TRANSFUSIONS

The development of a practicable system for blood transfusions and the establishment of blood banks are of vital importance to modern surgery. Every day, in almost every hospital, lives are saved by our present ability safely to replace blood loss. For those who have come into the profession within the last 15 years when blood transfusions have become so commonplace, it is hard to conceive the tragedy of severe hemorrhage and the futility of all our former attempts at therapy. I have sad memories of watching literally hundreds of young men die of hemorrhage in the slaughter of the first World War. No one then knew how to preserve blood, or in fact much

Dr. Griffith, who is Emeritus Professor of Anesthesia at McGill University, is Anesthetist-in-Chief and Medical Superintendent of the Queen Elizabeth Hospital, Montreal.

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CHLOROMYCETIN (chloramphenicol, Parke-Davis) is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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about grouping, cross-matching, Rh factor and all the other aspects of the present day transfusion service.

Chemotherapy

The discovery and introduction of sulfa drugs and antibiotics have caused revolutionary changes in surgery. Asepsis and sterile technique are still as important as ever, but operations are now frequently performed which, on account of the danger of uncontrollable infection, were formerly done only in dire emergency. Cesarean sections, to save the lives of mothers and babies, are now undertaken with much less hesitation than even 25 years ago, and puerperal fever has almost completely disappeared. Because antibiotics have reduced infection, mastoid operations have become unusual, radical sinus surgery has decreased, there are fewer infected glands of the neck to dissect, and rib resection for empyema is seldom necessary. Battlefield wounds of the first World War almost invariably became infected, and the results of infection were often more disastrous than the original injury. Now, thanks to the new chemotherapy, plastic and orthopedic surgeons can work with greatly increased effectiveness.

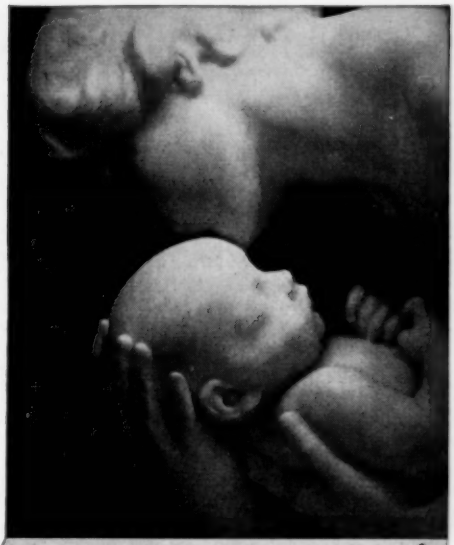
Anesthesia

It is more than 100 years since anesthesia was first introduced, but the great developments which have turned anesthesiology into a fast-growing and important medical specialty have all taken place within the last 40 years. Since it has been my fortune to be both a participant in and an observer of this march of progress, I am a prejudiced witness. However, it does seem to me that good modern anesthesia is one of the reasons for good modern surgery.

When I gave my first anesthetics in 1918 the whole anesthesia equipment of our hospital consisted of a bottle of ether, a bottle of chloroform, and a gauze-covered wire mask — not even airways, oxygen or a gas machine. Today, we have a multiplicity of anesthetic agents to be administered in a great variety of methods. All of the new drugs are not necessarily "advances," but nevertheless the patient is safer, more comfortable and less upset post-operatively than in the old days. Moreover, the surgeons can operate effectively in almost any part of the body. Better anesthetics and better anesthetists have played a big part in bringing about this happy situation. From the patient's point of view, the pleasant, rapid induction produced by pentothal and other intravenous agents is certainly a major improvement. Going under anesthesia is now just about the easiest and least dreadful of all hospital procedures. The skilful and frequent use of endotracheal tubes has brought safety to the patient in all situations where an obstructed airway so often occurred with old-fashioned anesthesia techniques. The anesthetist with an endotracheal tube can now control the patient's breathing regardless of awkward posture, depressing drugs or respiratory paralysis. This method has brought added safety in operations on the head and neck, the chest, and in many other situations.

The introduction of curare into clinical practice in 1942, followed by other muscle relaxant drugs, was a triumph of modern anesthesia because it brought the possibility of good abdominal muscle relaxation, for even the most difficult operations, without subjecting the patient to the added toxicity of prolonged deep ether or spinal anesthesia. Muscle relaxants are now used every day in every operating room throughout the world, so Canadians can have some pride in the fact that this was one of Canada's contributions to modern medicine. There is a plaque on the wall of the Queen Elizabeth Hospital of Montreal commemorating the first use of curare in anesthesia on January 22, 1942. It marks a milestone of medical progress.

Surgeons and anesthetists now work as members of a harmonious team. The other indispensable members of this team are the nurses. Canadian surgeons and anesthetists have been blessed with the presence of dependable, intelligent nurses at every stage of modern progress. Even the most famous surgeons would be helpless in an operating room without good nurses. Surgical nursing calls for scientific knowledge and technical skill, but it is still an art, and it is practised in



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Canada with devotion as well as with great zeal. I know that I speak for all Canadian surgeons and anesthetists when I say "thank you" to the nurses of Canada for all their years of loyal service. God bless you all!

From under the Blanket, 1908-1958

H. B. Atlee, M.D.

One night in 1908, as part of their medical training, four students sat on a bench in the poorhouse in Halifax watching a confinement. What they saw was an aging obstetrician, sitting some distance across the room at the bedside of a woman who was covered up to her chin by a blanket of the horse variety. The aging obstetrician had both feet in the Victorian era and both hands somewhere in under the blanket. Presently they came out from under the blanket — believe it or not — with a baby! He cut the cord, handed the baby to the nurse, walked over to us and said: "That, gentlemen, is the way to deliver a woman — no woman's private parts should be exposed to the gaze of a man." While this medieval spectacle was a decided anomaly as late as that date, it nevertheless must be accepted as an indication of the low state of obstetrical education at that time.

The patient, of course, had had no prenatal care, nor would she have a postnatal examination. The nurses of some of our leading general hospitals graduated in those days without ever seeing a delivery or having any practical obstetrical experience. Maternity cases were handled in the homes and only such emergencies as eclampsia, Caesarean section and placenta previa got into hospital, where they were more or less lost in the general surgical sections. In fact, in those days, fully trained nurses often knew much less about obstetrics than the untrained midwife — often a widow needing the money — who was omnipresent at domiciliary deliveries. The nurse in training, like the medical student, got no training in pre- and postnatal care.

Dr. Atlee is chief in obstetrics and gynecology at Victoria General Hospital, Halifax, N.S.

Largely owing to the work of DeLee and Williams, matters had even then begun to change. The women's magazines were taking up the evangel, not only defining what prenatal care should be, but urging on women that they demand it from their doctors. General hospitals began to set up maternity sections where not only emergent but normal obstetrics could be carried out. Hospitals dedicated entirely to maternity began to be built in most cities of any size. With the institution of these facilities both medical students and nurses began to receive a real training in practical midwifery. Specialist pediatricians began to be attached to the nurseries of such hospitals and under their increasingly expert care, the nursing of the newborn underwent immense changes for the better.

Today, in the same city that saw the four medical students bewildered and frustrated by the from-under-the-blanket exhibition of obscurantism described above, a very different situation exists obstetrically — as it does all over America. The medieval prudery has all but vanished. Students, doctors and nurses can see in countless delivery rooms every step of a labor that is seeable, and what they can't see the x-ray can explore for them. Furthermore, practically 100 per cent of the women in the community are delivered in hospital, all but a very few of whom have had prenatal care.

Without exaggeration it can be said that an amazing revolution has occurred in the last 50 years. Certainly an amazing revolution has occurred in the obstetrical education of nurses and doctors. Today, before these go out to practice, they have both witnessed and taken an active part in a large number of deliveries. They have also taken part in and been vitally concerned with the care of the newborn, prenatal clinics,

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well-baby clinics, and postnatal check-ups. While it must be admitted, sadly, that some of them after graduation tend to fall by the wayside in the care they give their pregnant women and babies, it is not because of a lack of instruction or urging on the part of their teachers. And despite some backsliding the situation continues steadily to improve: the revolution continues.

Since practically all women are now delivered in hospital, the architectural concepts within those hospitals are changing to meet the new conditions. When first built, maternity hospitals and sections were designed primarily to deal with the emergent case. The normal woman was still delivered at home and only the case with complications admitted to hospital. Today the hospital admits the vast majority of women with normal labor and, especially in the case of the primipara who tends to enter the hospital as soon as labor begins. It has to deal with women suffering various degrees of pain over a fairly long period of time. Because of this, and because, for all of these normal cases, delivery is a physiological and not a pathological process, we must change our hospital architecture and behavior to match the situation.

The new wing recently opened at the Grace Maternity Hospital, Halifax, carries into architectural effect what we hope is part of the answer to the problem of dealing more humanely and effectively with the normal pregnant woman. In this wing, at right angles to the regular labor section, but on the same floor with it, has been constructed the setup shown in the accompanying photographs. There is a large hall or ambulatory, where the woman in the long first stage is able to walk up and down, or sit and talk with her husband or friends. Off it on one side is a wide verandah where she can walk outdoors to better oxygenate herself and her baby. On the other side of the hall are small sitting rooms, more or less fitted out like the sitting room of an ordinary house, the chesterfield being of the day-bed variety on which she can lie down and be examined. In this room she can have her radio, her husband and her friends.

Patient's Sitting Room

The rationale of this setup can be summed up as follows:

1. The woman is kept out of the atmosphere of "blood, sweat and tears" associated with the actual delivery section, during most of her labor, yet is so

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2. Especially if she is a primipara, is new to hospitals and is going to be in for many hours before delivery, she comes into an architectural situation much more reminiscent of her home than of a hospital, and has a great deal of freedom of movement as well as freedom of entertainment. It is our distinct impression that this freedom shortens labor. Its distractions certainly make labor more bearable.

3. The verandah, when weather permits enables the woman to obtain much cheaper and more physiological oxygenation than ever came out of a tank, and in addition allows a sort of psychological escape.

But this is only the beginning of much more radical changes which we feel should be made in the handling of the pregnant woman to meet her emotional, as well as her physical needs. One of the great drawbacks to the laboring woman under the present situation is that — both as doctors and nurses — we approach her as a pathological problem. Until we change this attitude and accept her for what she truly is — a physiological process — we cannot say that women have become fully emancipated from the disabilities of their slavelike past.

For as long as we continue to adopt the pathological concept we, the doctors and nurses, will be having the baby — the woman remaining a more or less passive, and perhaps fairly deeply anesthetized agent. But when we adopt the physiological approach, we allow the woman herself to have the baby. We humble ourselves to the rank we should have in the face of this act of God — we become helpful and interested bystanders, ready to deal with any complication that may arise, but otherwise permitting the woman the privilege of completing this supreme achievement herself.

So far, this is a man's world. In making a place for herself in it, and realizing a satisfactory sense of achievement, women are at constant variance with their physiological destiny. That destiny is to have children. It is the one thing they can do that a man cannot! It should be yielded the prestige due it. Our present methods of handling the woman in labor as a completely pathological process in a very real way tends to destroy this sense of achievement and prestige.

The future revolution in obstetrics that I visualize for the coming fifty years will, I hope, restore to women the lost guerdon of her physiological destiny. It cannot come too soon to this increasingly neurotic and frustrated world.

In the Good Old Days

(*The Canadian Nurse* — JUNE, 1918)

At this time much is being said and written relative to standardization of hospitals and uniformity in training schools. There is no reason why our routine of procedure should not be the same in every hospital.

* * *

Persistent nausea and vomiting may sometimes be overcome if the patient inhales the fumes from hot vinegar.

* * *

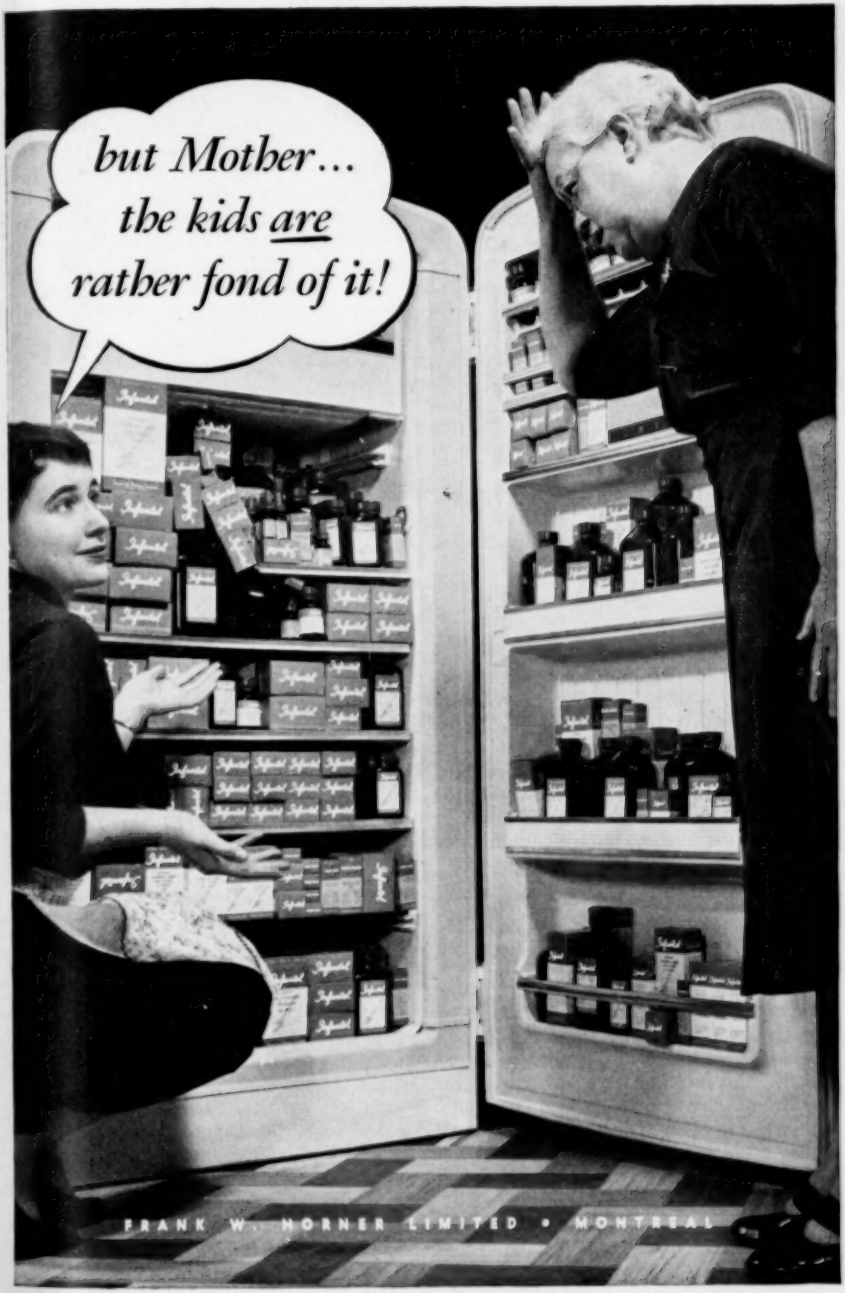
A writer in the *British Medical Journal*, who had reached his 95th year, attributes the satisfactory condition of his health and strength, in part, to the exercise of the muscular system. He especially recommends walking as the most natural of all exercises, particularly when accompanied by deep breathing and exercise of the arms.

* * *

The touch of individuality given to each training school in the adoption by each of a particular uniform, is, perhaps to be commended. But a "uniform" uniform, officially recognized and protected so that it could be worn or obtained only by registered nurses would do much towards placing the unqualified in the place to which they belong.

* * *

England is to have national kitchens. Varied meals will be provided for everybody at the lowest possible price, and there will be special invalid kitchens.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The Changed Role of Hospitals

L. O. Bradley, M.D., F.A.C.H.A.

A thorough review of the hospitals of Canada, spanning the lifetime of the Canadian Nurses' Association, would produce a several volume best seller. It would live with the despairs of failure, with drama and the excitement of the full range of human emotions, with unusual characters and personalities, with wonderful stories of devotion and loyalty and with successes and results in the category of miracles. It would describe the change in community attitude from one of awe and fear to the present position with the hospital as a familiar household word. For this contribution however, little more can be recorded beyond a listing of the most significant happenings.

It is unusual, if not unique, that the present administrator, of the Winnipeg General Hospital has been able to discuss the first years of this period (1908-1958) with the medical superintendents who were responsible for the hospital from 1904 to 1910. Much of the comparative material that follows was gathered from the annual reports written by Dr. A. M. Campbell (1904-1907) and by Dr. J. A. Gunn (1907-1910), the former still in practice, the latter now retired. During their professional lives, which parallels that the CNA, the hospital has changed remarkably — and yet — so much remains unchanged or yet to be accomplished.

Its Aims

The primary aim of the hospital — care of the sick and injured — remains the same but the scope of this purpose is much broader. At the beginning of this period, infectious diseases were found in the hospital; for several decades this group of illnesses was not admitted and only in recent years have these patients been admitted when home care was not sufficient. A few years ago, the average community hospital did not offer its services to the alcoholic patient or those with mental illness. Today, most of these hospitals attempt to meet all of the needs of the acutely ill and injured.

In its secondary functions — education and research — there has been remarkable growth. Almost every category of health personnel in some 35-40 professional and technical areas, receives all or part of its preparation within the hospital. The medical research department is now well established in larger hospitals and is an active function even in smaller units.

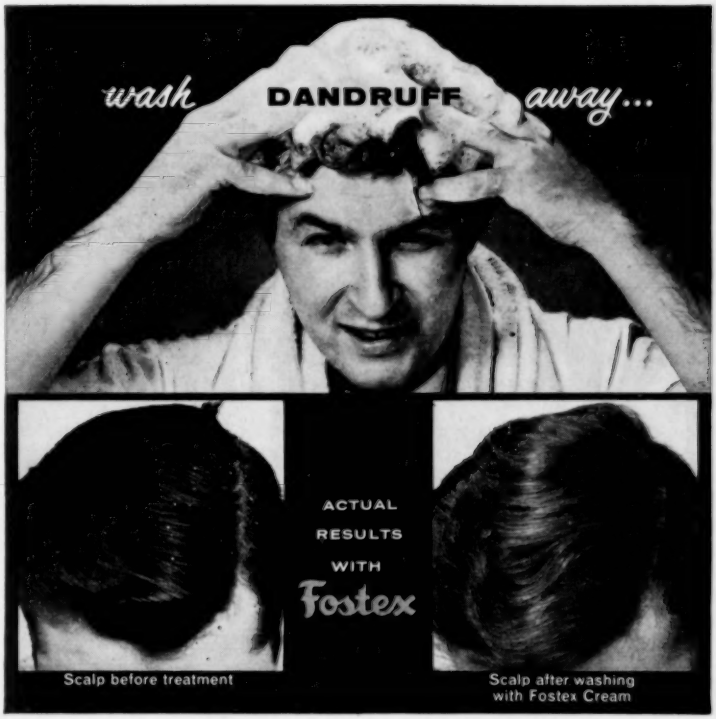
Its Physical Attributes

Many current administrators, planners and others take pride in a number of recent developments as new and exciting concepts. It is revealing to review the plans which were prepared in 1908, were introduced, used, discarded and are being rediscovered in 1958. The trend to smaller ward units which began early in this century gathered momentum in the post-World War II building boom, to firmly establish the 1,2,4 and 6-bed ward. One might predict a return of the pendulum to an 8 to 16-bed range as the nursing team concept becomes more widely understood and undertaken. Supervision and patient attention would be greatly facilitated because one member of the team would be present almost constantly.

The allocation and use of floor space has shifted steadily since the CNA was born. More and more space has been given to diagnostic and treatment services, rehabilitation, educational and research facilities, office accommodation for public health services, medical practitioners, and etc., until it substantially exceeds the allocation to patient or ward areas. There is no need to comment on sanitary conveniences, electrical services, better communications, layout, etc. for they are now taken for granted.

It may be well to record the reduction in beds per nursing unit from 50 to 70 or higher to 18-25 bed range in recent decades, only to hear of another reversal. Because of the current nursing shortage, recent improvements in su-

Dr. Bradley is the Administrator of the Winnipeg General Hospital.



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pervisory skills and techniques and better functional layout, some planners are again advocating units with 36-50 beds to better utilize professional personnel. The combination of the shortening workday and workweek with the increasing of activities about the patient, should temper this backswing since the maintenance of an adequate nurse-patient relationship must remain as always the important and determining factor.

Changes in Hospital Utilization

In absolute and in relative terms, Canadians have entered hospital more often and for more days each year from 1908 forward. The increase has moved upward through good times and bad and, throughout, has shown a very direct relationship to the number of beds in service.

Statistics available from the Ontario Department of Health (Table I) will be roughly paralleled in other provinces when factors of geography, development and economics are weighed. Several western provinces, notably Saskatchewan and Alberta have shown a much more rapid rate of increase during the last decade. Undoubtedly, the prepayment of hospital care, which for the first time became available to all rural dwellers under government hospital plans, was an important stimulus. Beds per 1000 of population reached a level of 7.5 in Saskatchewan and in several localities admissions exceeded 200 per 1000. With universal hospital plans available to all Canadians shortly, we may expect more rapid changes in the other provinces.

A few minutes in contemplation of Table 1 reflects the greatly changed position of the hospital in the health field. Where in 1908 one in 57 was admitted to hospital, by 1956 one in six sought hospital service. Fortunately, the average length of stay has dropped from 24 days to 9 days, a factor that has reduced the cost of a hospital stay very materially.

Hospital Service has Changed

The composition of the hospital population has changed. Formerly women were in the minority. Today we find the male relegated to this position. The increase of in-hospital deliveries has proceded so steadily that this remarkable

Table I

Comparison of Hospital Utilization in Ontario

For Years	1908*	1956
Population of Ontario	2,400,000	5,400,000
No. of hospitals	69	159
No. of beds	5.492	25,055
Beds per 1,000	2.3	4.6
No. of admissions	41,696	875,525 (includes 136,046 births)
Admissions per 1,000	17.3	162.1
Admissions per bed	7.6	34.9
Days of care	1,000,299	7,893,176
Days of care per 1,000	417	1,461
Length of stay	24	9
Total cost on maintenance	$1,239,236	$111,742,267
Cost per citizen	51¢	$20.70
Cost per day of care	$1.21	$15.81 (excludes newborn)

* The statistics of the 1908 column include 5 sanatoria for consumptives which would increase the length of stay and lower the cost of care. The 1956 column is for acute general hospitals, excluding Red Cross Outposts and hospitals for the chronically ill and convalescent.

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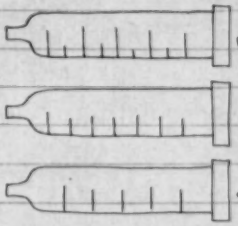

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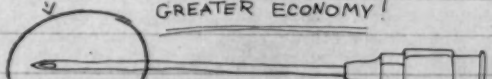

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TABLE II

Admissions by Service for Years 1908 and 1957 at Winnipeg General Hospital.

Service	1908		1957	
	Admission	%	Admission	%
Medical	1,611	32.7	4,891	20.8
Surgical	1,487	30.1	7,045	30.1
Gynecological	334	6.7	1,570	6.6
EENT	415	8.4	1,453	6.1
Infectious Diseases	583	11.8		
Obstetrical				
Mothers	280	5.7	4,494	19.1
Newborn	219	4.4	4,068	17.3
Total	4,929	100%	23,521	100%
Male	2,884	58.5	9,484	40.35
Female	2,045	41.5	14,022	59.65

change has provoked little comment. At the turn of the century fewer than 2 per cent of deliveries were born in hospital; now in most areas fewer than 2 per cent are born outside of the hospital. A tour of the other wards of the hospital reveals a shift in age group with the grey-headed patron much in evidence. This trend is of great concern to educators and administrators.

The increase in obstetrical admissions has been matched by the decrease in infectious and communicable diseases — a reflection of great advances in public health. (Table II) Recently however, the presence of the staphylococci in a multitude of situations reminds us that congregation in hospitals is a happy hunting ground for infection — if our defences are down. One might have expected a greater increase in surgical admissions, considering the more effective anesthetic and surgical techniques now available. A detailed review of surgical admissions and procedures carried out is much more revealing. There is a decrease in surgery for infections, notably tuberculosis; for sinuses, abscesses, necrosis, etc.; a significant increase in surgery of deep-seated structures and cavities, cancer surgery, neurosurgery, thoracic surgery, prostatectomies, etc. Transfusion of blood became safe and commonplace but now new hazards are following upon its overuse.

The effectiveness of hospitals has of course followed upon the growth of its diagnostic and treatment services. (Table III) Diagnosis is hastened and definitive treatment instituted more promptly. The results are evident in shorter stay and much improved recovery rate.

HIGH COSTS REFLECT PROGRESS

The most frequent comment or complaint heard about hospitals is of the high cost of hospital care. It is not difficult to understand this criticism of the community for they know not of what they speak. It is almost traitorous to hear it from doctors, nurses and others intimately associated with the hospital field. By and large, hospital people have interpreted poorly.

Hospital costs have climbed sharply in recent years for two reasons — both of them very apparent. The cost of supplies, food, drugs, general equipment and specialized scientific equipment has risen because of business decisions outside of the hospital. The cost of staff has moved up briskly because the competition of other employers has pressed up wages and salaries and improved working conditions. Unquestionably, the rate of increase has often been greater than other community services, but then the baseline of staff wages was

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TABLE III

Comparison of Patient Statistics at Winnipeg General Hospital.

For Years	1908	1957
No. of beds	325	750
Average length of stay	20.5	10.0
Admissions	4,718	24,397
Admissions per bed (hospital utilization factor)	14.5	27.1
Births	211	4,068
Ratio Births: Total Admissions	1:22.3	1:4.9
No. of operations	1,451	10,951
Lab. tests	10,386	225,581
Per patient admission	2.2	9.2
X-Ray		
Fluoroscopy	111	3,492
Radiograph	695	113,293
Per admission	.14	4.5
Death rate	7.6-6.29% (5 yr. range)	3.2%
Method of Charging	Fee for Service	All Inclusive
Cost per day	1.50 plus	Standard 13.40
Semi-private room charge	1.25-2.00 plus	S. Priv. 15.25-17.25
Private room	2.50-3.50 plus	Private 20.25-23.25
	Payable weekly in advance	Payable weekly in advance

lower and is only now approaching the community level. With the interprovincial and international demand for our well trained professional and technical personnel so great, the wage bill may be expected to continue its climb.

The second reason is evident in the Tables I and III and in the results of hospital care that are now taken for granted. The difference between the content of a day of care in '08 and one in '58 is at least as great as the advance from the Stanley Steamer of the olden days to next year's Cadillac. This is so, because the hospital reflects the amazing progress and developments in medical and allied sciences that have been introduced and applied during this century. Where once a single staff member could easily meet the needs of two patients or more, now two members of the staff or more are hard put to bring modern medicine to the patient. This is a fourfold or greater increase in staff and most of them with highly professional or technical skills which means greater cost.

PAYING FOR HOSPITAL CARE

At the beginning of this period the major portion of hospital revenue came from the patient, with a very small assist from municipal and provincial governments. A substantial donation to operating costs came from regular private donors and groups. The period closes with the probability that most hospital bills will soon be paid by a combination of federal and provincial support, plus a premium or sales tax contribution by every responsible citizen, with voluntary donations playing a smaller part. Prepayment of hospital care which became a force in the 1930's grew so successfully that it is being adopted as a complete instrument by 1958.

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Personnel

Both the ratio of staff to patients and the increasing variety of professional, technical, business and service occupations have been briefly introduced above. These changes reflect the specialization of hospital activities that stems from the forward march of medical science in this fifty year period — an advance greater than in all of recorded history. The fund of medical knowledge is so great that it must be divided for application. Again, the increase in staff numbers and the cost (23.16% of total budget in 1900, 47.2% in 1940, 55.25% in 1949, 65 to 75% in 1958) is more than offset by shorter stay and better results. At the same time, it should make one realize that hospital service is human service — the application of human faculties and skills to the relief of human ills. Hospital care will always require a high proportion of human resources and these of first quality of mind and soul.

Summary

The attitude of the community towards its hospitals has changed from a negative view point to positive support in a relatively short period of time. This follows upon recognition of accomplishments and a clearer understanding of the role of the hospital in the health of the community. This favorable attitude reflects the satisfaction of those served. We may expect demands for more care and, from a better informed public, for better care. Both are possible in the future if the community is prepared to provide the resources but not otherwise.

In Lighter Vein

Elizabeth W. Odell, R.R.C., B.A.

The Old Brigade

The bridge game over, a group of graduates, mostly of the early 1900's, sat chatting over their teacups. As is often the case when old friends get together, the conversation drifted back to old times in the hospital and the nurses' training of an earlier day. Asked what they remembered best about their own experience, two or three chimed in with:

"Hard work and long hours,"

"Long stretches of night duty, sometimes six months or more without a night off!"

"Sore feet were the rule rather than the exception."

One spoke feelingly about her fallen arches and the poor physical care given to nurses unless they were so sick they had to be admitted to the hospital.

Two mentioned the poor food given to nurses in their particular hospitals. This seemed to engender more bitterness than any one other grievance. Then, there was the lack of any interest, in the part of the authorities, in the nurse's off duty time excepting to make sure that she knew that nurses *"must not go out with internes."* No effort was made to point out places of interest in the community to pupils who might be strangers, far from their home environment.

"Oh yes," said one, "Don't forget the long dresses, the high black boots and the black cotton stockings!" and, added another "The starched collars and the long sleeves with the stiff cuffs! On my first vacation I went to a dance in evening dress with a big red ring around my neck!"

"But," I asked, "What were the good things? Were you glad that you went into nursing?"

"I enjoyed every minute of it," said one. "We knew our patients and we tried to make them comfortable. If one patient was found lying awake at night, we had to know the reason. We tried to forestall the well known questions of the night supervisor —

'Have you tried rubbing his back,

A graduate in 1915 from The Montreal General Hospital, Miss Odell is Associate Professor Emeritus in nursing education of Northwestern University, Evanston, Ill. She now resides in Montreal.

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nurse, or given him some hot milk? What is his temperature?' "

In spite of the tales of hardship and overwork and the sordid conditions existing in hospitals, as depicted in "The Bellevue Story," by the early twentieth century tremendous strides were being made. Florence Nightingale and those she had trained were now influencing the class of women going into nursing. Living conditions for nurses were improving, although Annie (Ross) Jardine, an early graduate of the Hamilton General Hospital School of Nursing, is quoted as saying: "Nurses nowadays wouldn't think much of our quarters. They were small, cramped, poorly furnished, and without heat except in the halls. But I still love to look back on my training days. There were so few of us, so close together and it was very intimate."

Not many graduates were employed on duty in the hospitals and, from their first days in the hospital, pupil nurses were called upon to assume a great deal of responsibility. One lady superintendent is quoted as saying "If they put graduates in charge of the wards, they will do it over my dead body!" One cannot help questioning whether this was the best thing for the patient, but it is certain that a large number of executives were turned out under this system. One graduate remarked "As a student, I was proud of running a big medical ward and getting the work done on time!"

One thing that stands out in my own memory is the fine type of women who taught nursing care. Kindness and thoroughness were the watchwords.

In spite of what seems to be a long list of grievances heroically related when nurses get together, there was an underlying loyalty, and, as with soldiers who have gone through the battle together, lasting friendships were formed, many of which have come down to the present.

Bright Eyes of 1958

On the same day, it was my good fortune to talk with one of today's student nurses. She had just returned from a skiing trip. Her eyes were sparkling and, to quote from The Night Before Christmas, "Her cheeks were like roses." She was so happy that her 44-hour week was arranged so that she could have two days off one week and one the next, for she loved to get away to the Laurentians. But now she must "get down to earth because there is a Pharmacology examination posted for tomorrow."

I plied her with the same questions I had put to the older group. What did she like best about her nursing course? She hardly knew because she liked it all. She held in high regard her affiliations in obstetrics, pediatrics, communicable diseases and especially psychiatry. She felt the latter training helped her to understand the patients better and also herself.

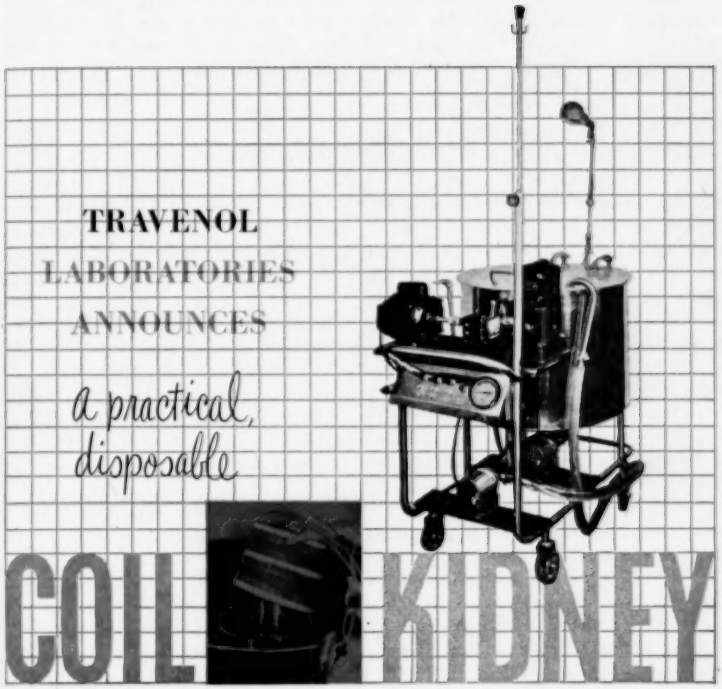
She wished that she could have more time to talk to patients but nursing procedures were so highly technical today that there was little time left for conversation. Most of the patients did not stay in the hospital very long and they always seemed to be on the move back and forth from one special department to another — to the x-ray, to metabolism, to the operating room. Getting everything in on time seemed to create a certain tension, perhaps just part of today's world picture.

The nursing school program was a heavy one but generous late leaves and a choice of recreational activities such as Glee Club, study groups in art or pottery together with the occasional dance, afforded the student a life comparable to that enjoyed by students in the better colleges.

When asked how she felt about student government, this student said she thought it was a good thing and that the girls valued the good opinion of their own group as much as that of faculty members. Voluntarily, she added that they also appreciated the individual instruction received by students while working on the wards.

In comparing nurses of the two eras, the old and the new, one must remember that this is a more youthful group. Instead of the entrance age of 21 or older, generally required for admission to schools of nursing in the early 1900's, when teaching and nursing were about the only vocations open to single women, the entrance age of 18, the same as that required by many universities, is practically universal.

The law of supply and demand operates in the nursing world as elsewhere.



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In order to meet the stiff competition from other fields of professional education as well as business opportunities open to women, it has become necessary to provide nursing courses that are comparable in academic content to those offered by the universities if we are to attract well qualified applicants. Living and working conditions both have been improved. One has only to read the resolutions framed by the Canadian Conference on Education held recently in Ottawa to realize that much still remains to be done in all fields of education. There is no doubt that with the fine group of young women entering our schools, nursing will play a creditable part.

In Memoriam

Patience Joanne (Bartley) Alexander, a graduate of Toronto General Hospital in 1908, died on March 7, 1958. She was 83 years of age. Her professional life prior to her marriage had been spent in private nursing.

* * *

Myrtle Marjorie (Martin) Barber died in March, 1958 at Winnipeg. During her professional career she had done supervisory work in Winnipeg Municipal Hospitals. She was the matron of Snow Lake Hospital for some time and later became the administrator and matron of Portage la Prairie Hospital.

* * *

Pearl (Rendell) Bartlett who graduated from St. John's General Hospital, Newfoundland in 1925, died on January 4, 1958 in Toronto.

* * *

Dorothy (Copp) Blanchard, a graduate of St. Joseph's Hospital, Hamilton, in 1933 died in February, 1958.

* * *

Elsie (Clarihue) Briggs who graduated from Winnipeg General Hospital in 1906 died recently.

* * *

Helena Fagan a graduate of St. Joseph's Hospital, Hamilton in 1917 died on May 21, 1957. She had been engaged in private nursing.

* * *

Margaret Kitchen, a graduate of Hamilton General Hospital, died on March 1, 1958. She had served in the Ontario Hospital, Hamilton and later in the City Department of Health before joining the R.C.A.M.C. during World War II. After the war she was with the Civil Service Health Division, Department of National Health and Welfare. At the time of her retirement in 1957 she was the assistant supervisor of nurses in that division.

* * *

Maryanne (MacLean) Lake who graduated at Galt, Ontario, in 1908 died on March 18, 1958.

Flora Elizabeth Livingstone who graduated from Orillia General Hospital in 1915, died March 17, 1958. From 1926-39 she was the night supervisor in the General and Marine Hospital, Collingwood. Following this, she spent several years in British Columbia, nursing in Burnaby and Victoria, until illness interrupted her career.

* * *

Lulu Miller, a graduate of Guelph General Hospital in 1938, died March 16, 1958 after a long illness.

* * *

Mary O'Connor who graduated from St. Elizabeth's Hospital, Louisville, Kentucky in 1923 died on February 27, 1958. She was a member of the St. Elizabeth Visiting Nurses' Association, Toronto.

* * *

Helen Stewart, a graduate of the Owen Sound General and Marine Hospital in 1920 died on March 23, 1958.

* * *

Elizabeth Webster who graduated from the Owen Sound General and Marine Hospital in 1903, died on March 23, 1958.

Are all T.P.R.'s necessary? A survey by staff members of one hospital showed the following results. A total of 97 hours over a 21-day period was devoted by staff members of three services to the procedure of early morning temperature recording. Of a total of 1876 temperatures taken, 1744 — or over 90 per cent — were normal; only 53 of 132 were elevated over 99.4° and these were confined mainly to patients who were preoperative, postoperative, newly admitted or suffering from head colds. A study of the results has brought about a change in the routine of each service in regard to early morning temperatures. Unnecessary temperature taking has been eliminated and patients are benefitting from extra hours of sleep and nursing care.

— *American Journal of Nursing,* April 1958.

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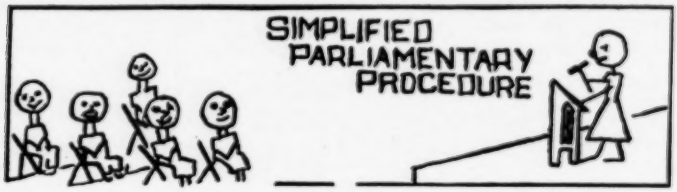


VI Other Types of Motions

Specific Main Motions

Motions 4, 5 and 6, as portrayed on the "ladder" in the March issue, provide the tools for reversing decisions already made or for cancelling them altogether. These three specific main motions are the ones most commonly employed in the conduct of business at a meeting. Less frequently used specific motions will be noted also.

To resume consideration (6)

When the discussion and/or vote on a general main motion has been "postponed temporarily" (laid on the table) it may be brought up again by a motion to resume consideration (take from the table). The form to be used is either:

> I move to resume consideration of the motion 'that this association establish a bursary fund for new graduates,'

or

> I move that the motion . . . be taken from the table.

If this motion receives a majority vote the business noted in the motion may again be discussed.

The motion to resume consideration may be made at the meeting immediately following the one when the matter was laid on the table or at any subsequent regular meeting. Since it takes precedence over an ordinary main motion it may be introduced whenever no business is before the assembly. It cannot be used, of course, to interrupt discussion that is in progress on a duly moved and seconded main motion.

To rescind (5)

The object of this motion is to repeal or erase from the minute book some action that has been taken previously. The motion may be stated something like this:

> I move to rescind the motion passed on March 11, 1956 by which action was taken to limit membership on the private nurses' registry to graduates of the local schools of nursing.

There are two important parts to that motion. First, the date when the motion to be cancelled was originally passed should be mentioned. There is no limitation of time so far as the motion to rescind is concerned. It frequently is used when an old motion has become outdated by present-day practices.

Second, the actual wording of the motion to be repealed should be given so that the members will know definitely what action is being nullified. The secretary should search old minutes, if necessary, to find the exact wording of the original motion. Only main motions may be rescinded.

There are a few instances when main motions may not be rescinded. For example, if a motion was passed authorizing the donation of $100 to the Cancer Fund, no motion could be made to nullify the donation after the treasurer has sent the cheque. Similarly, a duly authorized contract arrangement cannot be arbitrarily rescinded if the second party to the contract wishes it continued. If all arrangements were duly made to sponsor a soloist in a concert, for instance, the motion to handle the affair cannot be rescinded simply because the members are slow about the sale of tickets.

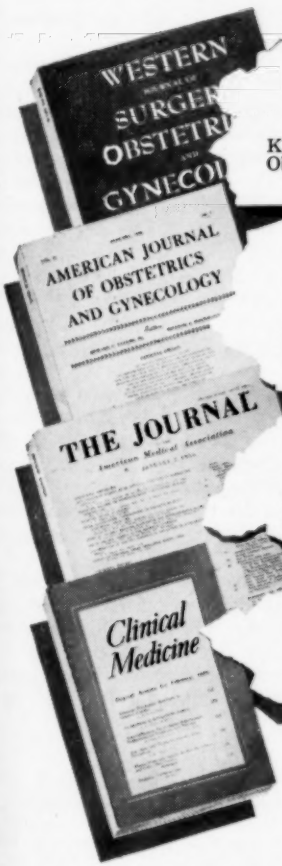
The motion to rescind may also provide for the deletion of the previous motion from the official records of the association. The secretary does not attempt to erase the old motion but writes across it, preferably in red ink, "deleted by order of the association" and the date.

To Reconsider (4)

Far less drastic than rescinding, the motion to reconsider simply sets

TAMPAX

a clinically accepted method of menstrual hygiene



"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

"Easy and comfortable to use and eliminated odor."

Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

Three absorbencies: Junior, Regular, or Super Tampax meet varying requirements.

TAMPAX

Professional samples and reprints of these papers furnished on request.

Canadian Tampax Corporation Limited, Brampton, Ont.

aside the vote that has been taken and opens the piece of business up to further discussion and a new vote. (When a main motion is reopened for discussion, new amendments may be proposed, it may be referred, or any other appropriate subsidiary motion may be made.)

A motion to reconsider is deliberately and definitely restricted in the matter of time. In a three-day provincial association convention, for instance, a main motion passed on the first day may be reconsidered that same day or on the second day but by the third day, it would be too late. An association that meets only once a month cannot, correctly, reconsider in October a piece of business that it passed in September. If it is necessary to nullify previous action a motion *to rescind* must be introduced.

This limitation as to time lends stability to the action of an organization and permits the officers or a committee chairman to proceed with the implementation of the action that has been approved. If the motion to reconsider is passed, it suspends all action in respect to the main motion being reconsidered until the latter is voted upon again. If an organization could reopen consideration of a matter even a week after it was first approved it could, conceivably, create considerable difficulty and embarrassment.

The same restrictions as were noted for the use of the motion to rescind apply to the motion to reconsider. In addition, reconsideration may not be given to any motion that requires previous notice to the membership. A typical example of the latter would be a motion to amend the association's constitution or bylaws. If it were possible to introduce a motion for reconsideration in the latter instance, it would be equivalent to voting on an amendment without the required notice having been given.

Privileged Main Motions

To Recess (3)

Frequently, an intermission is called during the course of a long meeting without a formal motion being made. If a motion is made, it usually specifies the length of time of the recess. A simple form may be used:

> I move that we take a 15-minute recess.
>
> *or*
>
> I move that we recess until tomorrow morning.

This motion must be seconded, is not debatable and takes precedence over all motions excepting the motion to adjourn.

The meeting should reconvene promptly at the expiration of the alloted time. Business is resumed at the exact place it was interrupted.

To Adjourn (2) (1)

This motion is made to bring a meeting to a close. It may be made at any time excepting when a member is speaking or a vote is being taken. It can be superseded by only one other motion. The latter may take one of two forms. It may make provision for the time at which the meeting will terminate — "I move that we adjourn at nine o'clock." It may set the time for the next meeting — "I move that this meeting be adjourned until ten o'clock next Monday morning."

When a motion to adjourn is moved *and seconded* before the business of the meeting is completed, it is the duty of the chairman to call the attention of the members to any important items on the agenda that should be decided before adjournment takes place. Having made this statement, the chairman must put the motion to a vote. If the motion is carried, the business that was interrupted by the adjournment is carried over to the next meeting and is included under "unfinished business" in the new agenda.

Next Month

Incidental Motions, Voting.

Transplantation of the third molar into the region of the first molar is now a feasible dental operation, within strictly defined limits. The purpose of transplantation is not only to maintain the integrity of the chewing mechanism but to prevent pain, occlusal interference, dislocation of other teeth, and other complications associated with the loss of a first molar.

— *American Journal of Nursing*, April 1958

Baby's Own Tablets

satisfactorily relieved

every one of 40 babies* with

constipation

and 34 out of 35 babies* with

teething

gastrointestinal upset and malaise

with complete easing of straining at stool, gas distress, disturbed sleep, restlessness, crankiness and anorexia.

REMARKABLY SAFE — "Throughout the study . . . in no instance was there any untoward reaction" whatsoever.

BABY'S OWN TABLETS provide Phenolphthalein 3/16 grain, mildly buffered with Precipitated Calcium Carbonate ½ grain, and Powdered Sugar q.s. Pleasant, convenient.

*2 months to 24 months of age.

For a sample supply and literature citing references 1-15 write . . .

Typical Case History

CASE #50. Baby R.S., age 12 months, weight 20 lb. 10 oz., had gastrointestinal discomfort and malaise associated with teething. Baby had no teeth as yet, but gums were tender, puffy and swollen. Baby was cranky, irritable, restless and couldn't sleep. Drooling was excessive; appetite poor.

BABY'S OWN TABLETS were given, one each night at bedtime.

Baby had satisfactory relief of symptoms. Appetite improved. First days, then nights, became more comfortable. Baby now has six teeth.

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PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

On the Eve of the 50th Anniversary

As we write these lines, National Office is a hubbub of activity. As you read this column, the hubbub will have increased to epic proportions as only "five more working days" will be left before the great event.

The 50th Anniversary celebrations will, we hope, be enjoyed by a greater number of Canadian nurses than ever before. At this stage all indications point that way.

Elsewhere in this issue you can read about **The Honorable Ellen L. Fairclough,** Minister of Citizenship and Immigration, who will be our guest speaker for the Mary Agnes Snively Memorial Lecture. All nurses will enjoy the opportunity of hearing and meeting this exceptional person who has become the first Canadian woman to be appointed a Cabinet Minister.

Nurses' Memorial — Hall of Fame

Just beyond the main entrance to the Parliament Buildings in Ottawa, in the Hall of Fame, is a beautiful memorial panel to Canadian Nursing Sisters.

Unveiled in 1926 in an impressive ceremony presided over by Miss **Jean E. Browne** (Mrs. J. E. Thompson), then President of the Canadian Nurses' Association, this memorial was erected by the CNA to honor Canadian Nursing Sisters who gave their lives in World War I.

Those attending the June Convention will want to make a special trip up to "The Hill" to view this tribute to our nursing forebears and to our profession.

Nursing Films

Student Nurse —] ıow, many of you will have seen t film prepared by the National Film Board for the television series "Perspective." Originally planned for release March 2nd — (a delay was occasioned by a change of programs that day) it was to be shown early in May. Filmed at the Montreal General Hospital, it depicts the arrival of a new group of students. It follows two of these students — one to successful completion of the nursing course, the other to the realization that nursing is not for her. The main actresses are professionals; many graduate nurses and students from MGH are seen throughout the film and all perform like veterans.

Designed to interest young women in the nursing profession and to explain nursing to the public, the film has achieved its objectives. Available for purchase from the National Film Board at approximately $65.00, it will be an excellent visual aid for those concerned with student counselling.

The Hands that Heal — Prepared by the Department of Citizenship and Immigration with the assistance of the Canadian Nurses' Association, this 20 minute film shows nurses from other countries who have settled in Canada in the various fields of nursing. Filmed for the use of the Department in various European countries where immigration to Canada is being encouraged, it gives a very good picture of the possibilities open to nurses in Canada and of the pleasant life which they may enjoy.

After many years of discussion in CNA circles concerning the need for a nursing film, it seems apportune that on the eve of our 50th year we now have two excellent films showing nursing in Canada. We are doubly pleased that on both occasions the assistance of the CNA has been sought by those planning these films.

Make Nursing
an adventure
with practical advantages

As a Nursing Sister with the Royal Canadian Army Medical Corps, you get the excitement of adventure and travel . . . serving with Canada's Army at home and overseas.

Opportunities exist to work in the various fields of nursing such as teaching and supervision, nursing administration, public health, and operating room techniques and management.

You receive officer's pay, allowances for uniforms, food and accommodation, plus 30 days annual holidays with pay.

You may apply for a Regular Army appointment for a lifetime career, or a Short Service Commission whereby you engage for a period of three, four or five years.

If you are a Registered Nurse, under 35 years of age, and a Canadian citizen or British subject, write now for full information, without obligation to:

Director General of Medical Services, Army Headquarters, OTTAWA, Ont.

Pilot Project

Preliminary Visits Completed

All schools of nursing, from Newfoundland to British Columbia, that are participating in the Pilot Project for Evaluation of Schools of Nursing have been visited by the Director, Miss **Helen Mussallem.** These visits have proved helpful and informative to all concerned. In meeting with the director to discuss the survey, the faculties of the schools had an opportunity to clarify points regarding the Pilot Project as well as learn something of the nature of the week-long survey.

Board of Review

Of special importance to the Pilot Project will be a board composed of members representing nursing education, nursing service, public health and registered nurses' associations to be known as the Board of Review. This Board will have the responsibility of reviewing and evaluating all survey reports. The Board of Review, now in process of being selected, will meet twice during the Project. The first meeting is to be held in late November, and the second meeting at the conclusion of the surveys, probably in March 1959.

Guidelines for the Future

As the Project develops, the need for the formulation of *national criteria,* for the evaluation of educational programs in nursing leading to a diploma, is most apparent. At present there are no such criteria in Canada. There is a real need for these to be written. They must be presented in such a way that they may be used in evaluation of diploma programs not only by the faculties of these programs, but also by those who may be evaluating the program through a survey.

The formulation of these criteria should involve the entire nursing profession. To get our thinking started on this important aspect of nursing education, a panel of experts at the 50th Anniversary Meeting will present their beliefs on what should be the

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REPEATING

Tired of REPEATING Dietary Advice

to Diabetic Patients?

Gain time . . . decrease repetitious talk. Suggest Knox Diabetic Diet Brochures. Based on nutritionally tested Food Exchanges[1], these diet Brochures demonstrate variety is possible for the diabetic, eliminate calorie counting and promote accurate individual adjustment of calories to the need of the patient.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

criteria in various parts of the educational program. A panel of questioners will discuss and seek clarification of these concepts.

As the criteria are presented, you may like the working blueprints or you may feel that they are idealized sketches of schools such as we may not see for a decade or two. Whatever your reaction, you will agree that the panel members have set guidelines for the future.

A Tribute

As each biennium draws to a close we become more and more conscious of the countless hours spent by so many nurses in the work of the various national committees. We, in National Office, are well aware of this invaluable contribution and we are most grateful. It is because of the work of these women that the nursing profession and our association are able to meet the demands of an increasingly health-conscious nation. It is because of this work that Canadian nursing reaches a standard of nursing care second to none.

Congratulations and thank you, for a job well done.

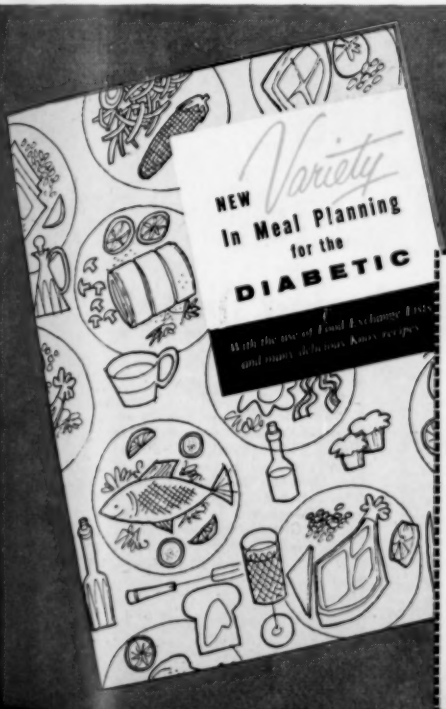
Le Nursing à travers le pays

A la veille de notre 50ième Anniversaire!

Au moment où nous écrivons ces lignes, le Secrétariat national bourdonne d'activité. Lorsque vous les lirez, l'activité sera à son apogée: il ne restera que cinq jours avant le grand événement.

Si nos prévisions sont justes, un plus grand nombre que jamais d'infirmières canadiennes prendront part au congrès biennal de cette année qui marque le 50ième anniversaire de L'Association des Infirmières Canadiennes.

Dans une autre partie de cette revue vous



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Your name and address

pourrez vous renseigner de L'Honorable **Ellen L. Fairclough**, qui prononcera l'allocution en mémoire de Mlle Mary Agnes Snively. Les infirmières seront heureuses d'avoir l'occasion d'entendre cette femme exceptionnelle, la première à devenir ministre dans le Cabinet fédéral.

Monument aux infirmières — Salle de la Réunion

A quelques pas de l'entrée du Parlement, à Ottawa, dans la Salle de la Réunion, se trouve un magnifique panneau en mémoire des infirmières militaires. Dévoilé en 1926, lors d'une cérémonie impressionnante présidée par Mlle **Jean E. Browne** (Mrs. J. E. Thompson), alors présidente de l'Association des Infirmières Canadiennes, ce panneau fut érigé pour honorer la mémoire des infirmières mortes au champ d'honneur durant la première guerre mondiale.

Les infirmières qui assisteront au Congrès voudront aller sur "la Colline" admirer ce monument qui fait honneur à nos disparues ainsi qu'à notre profession.

Film sur le Nursing

L'étudiante-infirmière — un grand nombre parmi vous ont déjà vu le film préparé par l'Office National du Film, pour la télévision, dans la série "Perspective." Le film devait être présenté le 2 mars mais à cause d'un changement dans le programme, sa présentation a été remise au début de mai.

Ce film tourné au Montreal General Hospital représente l'arrivée d'un nouveau groupe d'étudiantes; nous pouvons suivre deux d'entre elles: l'une jusqu'à la fin de son cours qu'elle termine avec succès, et l'autre, jusqu'à ce qu'elle se rende compte qu'elle n'est pas appelée à devenir infirmière. Les rôles des personnages principaux sont remplis par des acteurs de profession; vous verrez dans ce film plusieurs infirmières et étudiantes du MGH qui jouent comme des vétérans de la scène.

Ce film a pour but d'éveiller l'intérêt des jeunes filles dans la profession d'infirmière et atteint son but. Il peut être recommandé à ceux qui s'occupent d'orientation; on peut se le procurer à l'Office National du Film au prix de $65.00.

La main qui guérit — Film préparé par le Ministère de la Citoyenneté et de l'Immigration avec le concours de l'AIC — durée: 20 minutes. Ce film montre les infirmières de pays étrangers qui se sont établies au Canada et exercent dans les divers champs de la

TALKING

TALKING

Tired of TALKING Reducing Diets?

Save time . . . reduce tedious repetition. Suggest the Knox "Eat and Reduce" Booklets for cardiac, hypertensive and obese patients. Color-coded diets of 1200, 1600 and 1800 calories are based on Food Exchanges[1] . . . eliminate calorie counting . . . promote accurate adjustment of caloric levels to the individual patient.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

profession d'infirmière. Le film a été présenté par le Ministère dans divers pays d'Europe où l'émigration de la population au Canada est encouragée; il montrait les avantages dont peuvent bénéficier les infirmières au Canada et la vie agréable qui les attend.

Après des années de discussion au sujet de la nécessité d'un film sur la profession d'infirmière, il semble à propos, qu'à la veille de notre cinquantenaire, d'avoir deux excellents films sur le nursing au Canada. Il nous fait également plaisir de mentionner que dans les deux cas l'on a sollicité l'aide de l'AIC pour la préparation des films.

Le Projet d'Evaluation

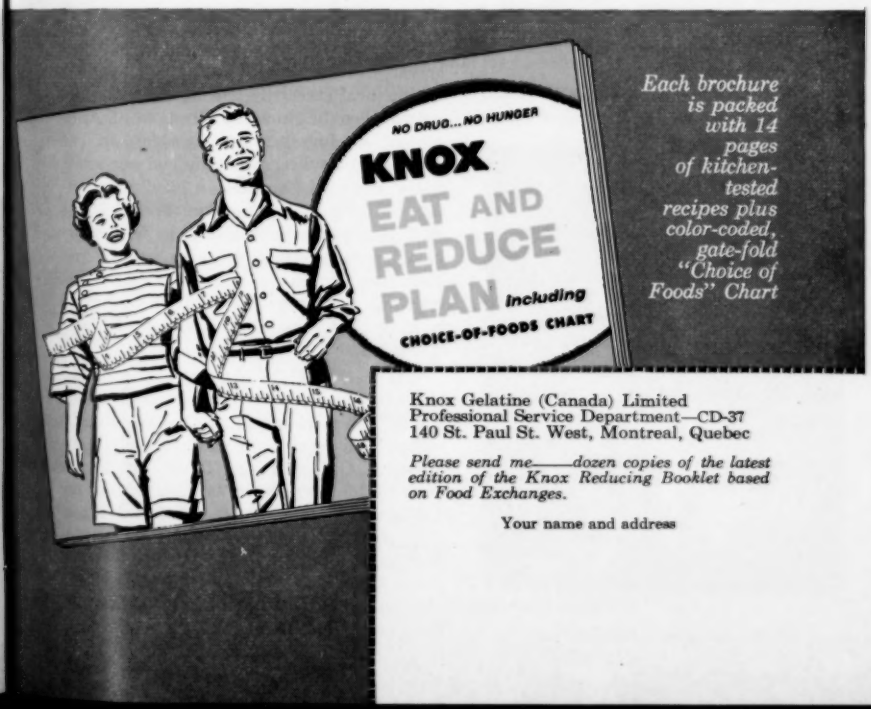
Toutes les écoles d'infirmières, de Terreneuve à la Colombie-Britannique participant au Projet d'Evaluation des Ecoles d'infirmières ont été visitées par la directrice du projet, Mlle **Helen Mussallem.** Ces visites se sont démontrées utiles, servant à renseigner toutes les intéressées. Ce contact avec la directrice du projet a permis aux directrices et aux facultés des écoles d'éclaircir certains points du projet d'évaluation et de se renseigner sur la nature de cette enquête d'une semaine.

Le Comité de Revision

Le Projet d'Evaluation des Ecoles d'infirmières nécessitera la formation d'un comité de revision composé d'infirmières exerçant dans le domaine de l'éducation, du service hospitalier, de l'hygiène publique ainsi que de représentantes des associations d'infirmières. Ce comité de revision aura pour but de reviser et d'évaluer toutes les enquêtes faites. Les membres du Comité de revision seront choisis sous peu et se réuniront à deux reprises: à la fin de novembre puis au terme de l'enquête, probablement en mars 1959.

Directives pour l'avenir

A mesure que le projet d'évaluation progresse, il devient nécessaire de formuler des normes nationales pour l'évaluation des programmes du cours de base. Actuellement, il n'existe pas de tels critères au Canada et la rédaction de ces normes s'impose. Il faudrait les présenter de façon qu'elles puissent servir non seulement aux membres de la faculté pour faire l'évaluation de leur école mais aussi aux personnes chargées de faire l'enquête sur l'école. La profession d'infirmière, dans son ensemble, devra être considérée lorsqu'il s'agira de formuler ces critères. Afin de stimuler notre pensée sur cet aspect important de l'éducation de l'infirmière, un groupe d'experts exposeront, lors du Congrès



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du 50ième anniversaire, leurs points de vue sur ce qu'ils croient être les critères d'un bon programme d'éducation. Des questions seront posées par un groupe de personnes afin que les idées générales soient clairement exprimées.

Ces critères pourront vous paraître comme des plans réalisables ou comme ceux d'écoles modèles que nous ne verrons pas avant 10 ans ou 20 ans; quelles que soient vos réactions, vous serez d'accord sur ce point que nos experts nous ont donné des directives pour l'avenir.

Un Hommage

Au terme de chaque congrès biennal, nous nous rendons compte du nombre d'heures de travail consacrées par les nombreux membres des divers comités nationaux à cette organisation. Au Secrétariat national, nous sommes à même de juger de l'importance de cette contribution au succès de nos affaires et nous leur en sont infiniment reconnaissantes. C'est grâce à ces femmes, à leur travail, que la profession d'infirmière et notre association peuvent répondre aux demandes d'une nation qui s'intéresse de plus en plus à la santé. La réputation sans égale de l'infirmière canadienne est le fruit de ce travail et de ce dévouement.

Félicitations et reconnaissances pour une tâche bien accomplie!

Convention Personality

TRADITION IS A POWERFUL factor in our everyday lives. The dictionary states that tradition is "the handing down of knowledge, beliefs and customs from one generation to another." Thus, the biennial salute to the memory of the great nurse who was the founder of the Canadian Nurses' Association, Miss Mary Agnes Snively, is one of the potent traditions of our profession. For the past 22 years a memorial lecture has been the highlight of the pre-closing ceremonies at the conventions.

Chosen to present the oration in Ottawa this month is the **Honorable Ellen Louks Fairclough,** Member of Parliament, Minister of Immigration and Citizenship. A fifth generation Canadian of United Empire Loyalist descent, Mrs. Fairclough has resided in Hamilton, Ontario, all her life. She entered upon a business career following graduation from high school, qualified as a certified public accountant, and opened her own office in 1935. Her husband owns and operates a printing establishment in Hamilton.

(Garnet Hollington)

HON. ELLEN FAIRCLOUGH

Formerly vice-president of the Young Conservatives of Ontario, Mrs. Fairclough opened her political career by seeking election as an alderman on the Hamilton City Council. After serving for four years as an alderman, one year as a controller, she sought and won a seat in the House of Commons in 1950, representing the riding of Hamilton West. Thrice re-elected in the same riding, to Mrs. Fairclough goes the honor of having been the first Canadian woman to achieve cabinet rank. She was Secretary of State from June, 1957 to May, 1958 when she was appointed to her present post.

Mrs. Fairclough takes a very active interest in women's work. A past president of the Zonta Club of Hamilton, she has held several offices, both provincially and nationally in the Imperial Order of the Daughters of the Empire. She has served as a member of the Canadian delegation to the United Nations. She was a delegate to the Conference of Parliamentarians from NATO countries in Paris in 1955.

A well informed, vigorous speaker, Mrs. Fairclough will do honor to our tradition.

For the Children You care for . . .

Nurses know that the great value of Crown Brand Corn Syrup in infant feeding formulae and on baby cereals cannot be underestimated. Crown Brand Corn Syrup contains the balanced mixture of Dextrin, Dextrose and Maltose that doctors recommend . . . in an easily digested . . . well tolerated . . . ready-to-use form.

Nurses know, too, that Crown Brand is the perfect energy food for children at all stages of their growth . . . and so easy to serve on cereals, on bread, or as a delicious dessert by itself.

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Also recommended for Infant Feeding

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Nursing Profiles

Dorothy Isabel (MacRae) Warner R.R.C. has been appointed Chief Nursing Officer of the St. John Ambulance in Canada. She succeeds Miss **Mary Acland** who has served in this office for the past 6 years.

Mrs. Warner is a familar figure to many Canadian nurses. A graduate of the Montreal General Hospital, she was an instructor at the Medicine Hat General Hospital for several years before returning to her home hospital as surgical supervisor in the Outpatient Department. Later, after some time spent as a night supervisor and floor supervisor at M.G.H., she became matron of Anson General Hospital, Iroquois Falls, Ont. Then in 1940, Mrs. Warner joined the R.C.A.M.C. and went overseas as matron of No. 1 Canadian General Hospital. In 1944 she was appointed Matron-in-Chief of the R.C.A.M.C. Nursing Service in Canada.

After demobilization she took postgraduate study at the McGill School for Graduate Nurses and subsequently was appointed director of nursing at the Reddy Memorial Hospital, Montreal where she served for two years. Latterly she has been nursing at various times in the General Hospitals of Montreal, Calgary and Vancouver.

Mrs. Warner comes to her present position with a thorough knowledge of, and a deep interest in the work of the Order of St. John. Her husband, the late Dr. Warner, had held the honorary appointments of Hospitaller of the Order of St. John in Canada, and Surgeon-in-Chief, for a number of years. As Chief Nursing Officer, she will be the nursing consultant and advisor on all phases of St. John Ambulance training and service in home nursing, child care and related fields.

C. Louise Bartsch is the Director of Nursing, Union Hospital, Moose Jaw, Sask. A graduate of Toronto General Hospital, Miss Bartsch is a Maritimer by birth and received her early education in her home city of Saint John, N.B.

Following graduation, she accepted a position as night supervisor at the General Hospital, St. Catherines, Ont., later becoming supervisor of the operating room. From 1931-42 she was the operating room supervisor in the Saint John General Hospital. Since that time, with the exception of two years spent in the service of UNRRA, Miss Bartsch has been associated with the Royal Edward Laurentian Hospital first as assistant

DOROTHY WARNER

LOUISE BARTSCH

director of nursing and subsequently as director of nursing.

In her leisure time Miss Bartsch enjoys her contacts in the University Women's Club or indulges her love for reading or travelling.

The appointment of **Luise H. Baptist** as Director of Nursing, General Hospital of Port Arthur was announced early in April.

A graduate of the Montreal General Hospital, Miss Baptist served overseas with the R.C.A.M.C. during World War II. Her first appointment, after returning to civilian life, was as operating room supervisor at the Saskatoon City Hospital. Later she enrolled in the McGill School for Graduate Nurses and successfully completed studies for her Bachelor's degree in nursing. After completing her postgraduate studies, Miss Baptist worked with the Ministry of Health in the Province of Quebec. While in Montreal she assisted an industrial firm in piloting an employee health program. She subsequently joined the teaching faculty of the General Hospital, Hamilton. Immediately prior to her present appointment she was the Associate Director of Nursing, Jewish General Hospital, Montreal.

(Harvey Rivard)

LUISE H. BAPTIST

Rita Mary Ball has become the new Director of Nursing Service, Trail-Tadanac Hospital, Trail, B.C.

Born in British Columbia at Vernon, she

RITA M. BALL

received her elementary education in that province, then came to Ontario to continue her high school studies. She is a graduate of St. Michael's Hospital, Toronto, and holds her certificate in teaching and supervision from the University of Toronto. Miss Ball spent several years on the staff of Mount Sinai Hospital, Toronto before becoming the Director of Nursing Education at Misericordia Hospital, Edmonton, Alta. She remained in this office during the years 1940-57.

Miss Ball took an active interest in the activities of the Edmonton district of the A.A.R.N., serving as secretary and later as president. She also filled the roles of chairman of the district Committee of Nursing Education and chairman of the provincial committee Film Pool of the Committee of Nursing Education.

Early this year **Agnes Catherine MacDonald** fulfilled one of her dearest ambitions in life when she started on her journey to the Loloma Mission in Northern Rhodesia. She will serve there as a nurse-missionary.

Miss MacDonald is a native of Glace Bay, N.S. and a graduate of the General Hospital, Glace Bay in 1953. In preparation for her work abroad she took postgraduate training

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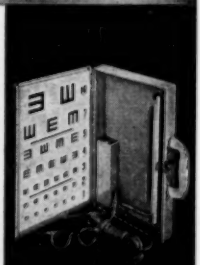
The Good-Lite Model A Translucent Eye Chart combines built-in fluorescent lighting and a washable plastic eye card for CONTROLLED light. Available in Snellen or Childrens "E" card models. $35.00

2. HYPEROPIA

The Optional Hyperopia Test locates farsightedness quickly and accurately with the addition of +2.00 lenses and a Good-Lite Eye Chart. For use with the Model A (above) or model B Charts (right). The addition of the glasses expands your Good-Lite system to a 2 point test. Hyperopia glasses $8.00



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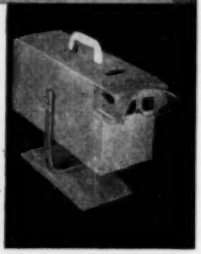

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at the Grace Hospital, Halifax. She served on the staff of her home hospital until preparations for her present appointment were complete. The very good wishes of her friends for her success and happiness go with her.

News Notes

ALBERTA

DISTRICT 3

CALGARY

Holy Cross Hospital

Mrs. (Benson) Lutz is working in the pediatrics department of the General Hospital. E. Linders recently returned from Hawaii and is on the staff of St. Michael's Hospital, Lethbridge. Mrs. A. Kloepfer is a director of the Canadian Cancer Society in the Winnipeg branch where she also convenes the educational program of the society in that area. M. (Caton) Haupt is on the staff of Eckville Hospital. The class of September '55 held a reunion in honor of P. Farrell who has gone to the University of New York for postgraduate study. Classmates of E. Wannop gathered to greet her at the home of Mrs. A. Wannop recently. Miss Wannop, who is a health nurse on the staff of a Toronto insurance firm, was visiting in this area.

DISTRICT 8

LETHBRIDGE

Municipal Hospital

Executive officers for the Galt School of Nursing alumnae association are: Mrs. R. Rice, pres.; Mrs. S. Phalen, Mrs. C. Reynolds, vice-pres.; Mrs. J. Wilson, rec. sec.; C. Walks, corr. sec.; B. Penner, treas.; Mrs. M. Barrett, Miss L. Osecki, social committee. At the capping ceremony each student received the gift of a Nightingale lamp from members of the association. Bamboo curtains have been presented to the undergraduate nurses for use on their sundeck and the members of the graduating class are to be the guests of the alumnae association at a banquet.

BRITISH COLUMBIA

PENTICTON

General Hospital

Mrs. Inez Brown who has been in charge of the maternity wing for the past six years has left to take a similar post at the North Vancouver General Hospital. Prior to her departure a presentation of a fitted overnight case was made to her by the local chapter of the Registered Nurses' Association.

VANCOUVER

St. Paul's Hospital

S. (Courtenay) Clark has joined the staff of the American Can Company as industrial nurse. Mrs. I. (Brown) Brown is now in charge of the maternity department, North Vancouver General Hospital. Sr. Anne of the Sacred Heart, pediatric department, is being transferred to Fort St. John as superior. Mrs. Gowan has joined the staff of the Seymour Clinic. The alumnae dinner dance was held at Capilano Gardens early in April. Dr. Musgrove and Dr. R. Robertson have been guest speakers at recent meetings of the association. The former discussed gastric surgery and the latter, cardiac surgery.

MANITOBA

BRANDON

General Hospital

Dr. J. Hendry, pathologist, was the guest speaker recently at a meeting of the alumnae association. Using the Rh factor as his topic, he gave his audience an excellent orientation to this subject and to the complication with which it is so commonly associated — erythroblastosis. A question period provided a welcome opportunity for his audience to clear up additional queries related to the Rh factor. Representatives attended the annual provincial convention in Winnipeg and delegates have been chosen to go to the CNA Biennial Meeting, Ottawa.

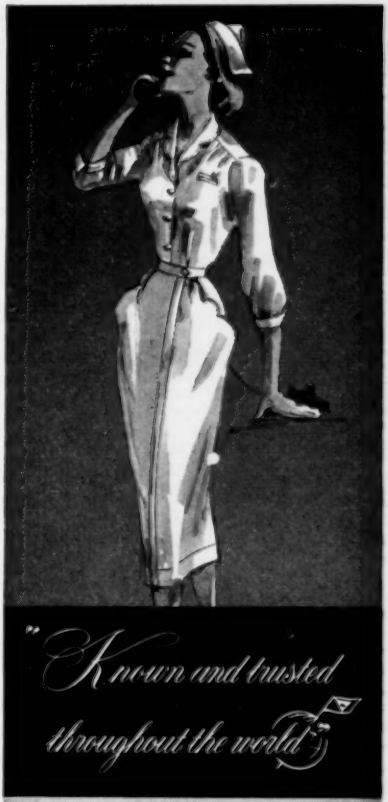
WINNIPEG

Children's Hospital

The result of the election for alumnae executive officers is as follows: L. Scorer, pres.; Mrs. D. Moore, S. Stark, vice-pres.; D. Coffey, rec. sec.; Mrs. D. Patterson, treas.; M. Irwin, corr. sec.; Mmes. K. McCord, H. Davis, news bulletin; Mrs. J. Chapman, rep. to *The Canadian Nurse*. During 1957 the alumnae association donated $2600 to the hospital for use in the purchase of furniture for the library in the new residence. The Nursing Bank — a project begun less than two years ago — contributed over $200 worth of care to indigent patients in need of special nursing. The care was given mainly to very ill babies and children with tracheotomies or other major surgery. Pearl Greenaway obtained her diploma in teaching and supervision from the University of British Columbia in 1957. Pat Scorer is attending the same university where she is completing final studies for her B.Sc.N. Claire Etta Johnson is taking a six-month postgraduate course in operating room technique, Baylor University Hospital, Dallas, Texas.

General Hospital

Miss Rae Abernathy, executive director of the Age and Opportunity Bureau was the guest speaker at one of the regular alumnae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meetings. The Bureau has been in operation for only one year and the information concerning it was most interesting. A buffet supper in mid-March provided an opportunity for friends to express their good wishes to M. Schumacher, Mrs. L. McGinnis, Mrs. J. Downs and J. McLenaghen who have resigned from the staff. A silver tray bearing the crest of the hospital was presented to each one. Congratulations are extended to J. Kobar on her promotion to the position of head nurse and to I. Cooper who has been appointed a relief instructor in maternal health in Alexandria, Egypt.

NEW BRUNSWICK

MONCTON

Nurses' Hospital Aid

Mrs. W. Buxton and Mrs. K. Mayhew who attended the annual dinner and meeting of the Local Council of Women reported about this event at a recent meeting. Mrs. Buxton and Mrs. J. H. Pettigrew are to attend the Maritime Hospital Auxiliaries convention in June. Plans have been made for the annual graduation dinner and dance in honor of the class of '58 who will complete their training shortly.

NEWFOUNDLAND

ST. JOHN'S

General Hospital

The following members comprise the executive of the alumnae association for the current year: R. Nicolle, pres.; K. Roche, vice-pres.; Mrs. J. Shave, sec.; Mrs. E. Hilliard, assistant sec.; Mrs. J. Higgins, treas.; Mrs. E. Candow, assistant treas.; P. Godden, G. Rowsell, F. Milis, committee conveners. The alumnae association will be represented at the CNA Biennial Meeting by R. Nicolle and P. Godden.

NOVA SCOTIA

SYDNEY

A potluck supper was arranged by the public health nurses of the area as a special feature of one of the regular chapter meetings. These nurses had just moved into their new quarters in the recently completed Provincial Building, Sydney. Proceeds from the supper were used for expenses in connection with the annual provincial meeting.

ONTARIO

DISTRICT 1

WINDSOR

The following members have accepted executive offices in the district association for the current year: Mrs. Mary Smith, pres.; Laura W. Barr, Mrs. Ruby McDonald, vice-pres.; Fredrica Lyons, sec.-treas. Chapter presidents are as follows: Phyllis L. Black, Windsor-Essex Co.; Mary A. Langford, Kent Co.; Mrs. Lillian Lossing, St. Thomas-Elgin Co.; Ruth M. Showers, Sarnia-Lambton Co.; Mary E. Feeney, London-Middlesex Co.

Hôtel Dieu Hospital

The junior students were guests of honor at a luncheon given by the alumnae association and highlighted by the presentation of *The Canadian Nurse* award to Joan Marie Marshall. Sharon Schiller, second in line for the award, received a gift subscription to the *Journal* from the director of nurses and an award pin that will be passed along to a member of next year's class. Mrs. Pillar has returned to the staff of the hospital and is working on the pediatric ward. D. Bombardier and

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A. Gauthier have gone to Bakersfield, California. Y. Tremblay has been elected president of the city's Medical Secretary Association.

District 3

Owen Sound

General and Marine Hospital

Funds have been donated by the alumnae association for a modern nurses' lounge in the newly completed wing. In addition the student nurses have received financial assistance toward the expenses of their annual spring dance. Mr. A. Cooper, local sanitary inspector, was the guest speaker at a recent alumnae meeting.

District 6

Belleville

General Hospital

A coffee party to which all graduate nurses from the city and district were invited proved very successful in spite of poor weather. Everyone enjoyed the evening of visiting and many expressed the desire for a similar party as soon as possible. Dr. H. Neumann was the guest speaker at the March meeting. He discussed the special aspects of the care of a patient following chest surgery. A hat sale was a feature of the April meeting and, in addition, a guest speaker discussed "Fashions." Also, in the same month, the alumnae association arranged for "An Evening in Dogpatch" — a gay, informal social function.

District 8

Ottawa

During 1957 district members had the special pleasure of hearing Mr. J. W. van der Vassen of the Netherlands Embassy discuss Dutch paintings at their general meeting. Mr. van der Vassen illustrated his lecture in a most delightful manner. At the annual meeting Miss Carol Adams, R.N.A.O. nursing education secretary, was the guest speaker. The 1957 Spring Fashion Show and Fall Bazaar were both very successful ventures. A profit of $2744 was realized and enabled this area to forward its contribution to the furnishing fund of the new R.N.A.O. building. In addition $200 has been donated towards a reception to be held in connection with the CNA Biennial Convention.

District 10

Port Arthur

General Hospital

The following members form the current year's executive: Mrs. W. Perttula, pres.; Mrs. H. Sellick, vice-pres.; L. Hynna, sec.; A. McRorie, treas.; Mmes. M. King, W. Lowcock, news bulletin; M. Morgan, press.

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Miss L. H. Baptist, recently appointed the director of nursing and nursing education, was made an honorary member of the association. Mrs. J. Dawson was appointed to the School of Nursing Advisory Committee replacing D. Elliott who has gone to California. Mmes. G. Parker and A. Chase were the recipients of honorary life memberships indicating that each one has been a member of her association in good standing for 25 years or more.

QUEBEC

MONTREAL

General Hospital

The members of the alumnae association held an impressive ceremony in Livingston Hall in March when an honor roll of the nurses who served in World War II was unveiled by Colonel L. C. Montgomery, O.B.E., M.C., V.D., Legion of Merit. The chairman for the occasion was Mrs. Stuart Ramsay, R.R.C. The invocation and benediction were pronounced by the Rev. De Witt Scott, D.D., who served as padre of No. 14 Canadian General Hospital Overseas.

In presenting the honor roll to the hospital, Miss B. G. Herman, R.R.C., president of the alumnae association, spoke of the outstanding work done by the overseas nursing sisters. She pointed out that of the 238 members listed, one was admitted as a Member of the British Empire, one was awarded the Distinguished Service Medal of Greece, five received the Royal Red Cross, five the Associate Royal Red Cross and four were mentioned in dispatches.

Before unveiling the honor roll, Colonel Montgomery gave an interesting review of the history of the Canadian hospitals in the United Kingdom and the Italian area. He described the activities of the nursing sisters recalling amusing anecdotes and incidents. He paid tribute to the work of the many M.G.H. nurses who served in both World Wars.

Lt. Col. W. W. Ogilvie, E.D., in accepting the honor roll on behalf of the hospital remarked that one out of every five nurses who had graduated from the School of Nursing since its inception in 1890 had served in one or other of the two World Wars — an outstanding record of which the hospital is justly proud. Following the ceremony, coffee was served in the lounge.

The alumnae association is greatly indebted to Miss Phyllis Walker and her committee for all their efforts in assembling the names of the nurses and planning the details which made the honor roll possible.

Queen Elizabeth Hospital

The alumnae association recently elected its new executive. The following is a list of the members comprising it and their offices: E. Geiger, hon. pres.; F. Bryant, pres.; P. Poole, W. Duncan, vice-pres.; E. Williams, sec.; D. Hodges, asst. sec.; K. Grant, treas.; R. Matsubuchi, asst. treas.; Mrs. S. Wardrop, D. Henshaw, E. Hughes, public relations; Mmes. B. Pow, P. Pugsley, Montreal Council of Women; Mmes. S. Henderson, B. Perey, entertainment; J. Tomalty, H. Hurley, refreshments; I. Garrick, Sick Benefit; Mrs. C. Curtis, membership convener; M. Currie, social secretary.

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SASKATCHEWAN

SASKATOON

St. Paul's Hospital

Executive officers for the alumni association are as follows: Sr. J. Quintal, hon. pres.; M. H. Dingwall, pres.; Mmes. J. Robertson, I. Bickle, vice-pres.; J. Gladstone, sec.; Mrs. J. Parres, treas.; Mmes. R. McKay. I. Metcalf, W. McIvor, J. R. Fewster, councillors; Mmes. W. Haid, W. Patrick, F. E. Fulton, J. Mahoney, Miss M. O'Hara, committee conveners.

Employment Opportunities

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Quebec.

Director of Nursing for 91-bed hospital (Construction of new 240-bed hospital to commence as soon as weather permits. Excellent opportunity for an individual with initiative & organizing ability. Commencing salary: $340-$390 per mo. depending on administrative experience. Annual increments. Accommodation provided at nominal charge. Please address applications stating qualifications, experience & date available to Administrator, Prince George & District Hospital, Prince George, British Columbia.

Registered Nurse for **Matron** for modern 20-bed hospital (Duties to commence August 1st.) 1-mo. vacation after 1 year. Sick leave. Living quarters adjoining hospital. Apply, stating experience & salary expected to: Secretary-Treasurer, Memorial Hospital, Deloraine, Manitoba.

Matron: Required for modern 15-bed Maidstone Union Hospital. Salary $325 per mo.; one mo. vacation with pay after one yr. of service. 2 wk. sick leave with pay allowed per yr. $30 per mo. deducted for full maintenance in modern new residence. Duties to commence July 6, 1958. Apply: Matron, Maidstone Union Hospital. Maidstone, Saskatchewan.

Assistant Superintendent (Immediately) for General Hospital. Attractive living quarters, 5½-day wk. 30-day vacation per yr., sickness benefits, etc. Knowledge of laboratory procedure desirable, but not essential. Salary commensurate with training and experience. Apply: Porcupine General Hospital, South Porcupine, Ontario.

Assistant Matron with postgraduate preparation for 140-bed hospital with building program in operation. For further information, write Acting Matron, King Edward VII Memorial Hospital, Bermuda.

Registered General Duty Nurses & Assistant Superintendent (1) for Modern 21-bed hospital. Apply: Mrs. Emery Robertson, Supt. Tobique Valley Hospital, Plaster Rock, New Brunswick.

Assistant Night Supervisor — Head Nurses for Medical & Surgical Wards — **General Duty Nurses** for 450-bed hospital with training school. Excellent personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

Operating Room Supervisor for large Sanatorium. Experience in Chest Surgery desirable. Salary according to qualifications. Good personnel policies. Apply Director of Nursing Service. The Beck Memorial Sanatorium, London, Ontario.

Operating Room Supervisor, Night Supervisor, Assistant Head Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

Operating Room Assistant Supervisor: preferably with postgraduate course. **Registered Nurses, Certified Nursing Assistants,** 60-bed Hospital, 51 miles from Ottawa. For personnel policy; Apply; Superintendent, The Great War Memorial Hospital, Perth, Ontario.

Operating Room Nurse (1) — with P.G. or experience. (June 15) **Charge Nurse (1)** for medical floor (June 15) **General Duty Nurses** & summer relief required for a 105-bed modern hospital in the Okanagan Valley. Present basic wake is $244 for B.C. Registered general duty nurses. A new contract to be written shortly. For full details write to: Mrs. L. E. O. Thom, Supt. of Nursing, Vernon Jubilee Hospital, Vernon, British Columbia.

Science Instructor — Clinical Instructor for General Hospital — 40 students — 1 class a year. For further information please apply to Director of Nursing, St. Joseph's General Hospital, Vegreville, Alberta.

Medical—Surgical Instructor. R.N.A.B.C. personnel policies. Minimum salary: $3,600 per yr. Apply Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Clinical Instructors in Surgery & Pediatrics for 450-bed hospital. Good personnel policies. Please apply to: Director of Nurses, St. Joseph's Hospital, Victoria, British Columbia.

Department of Public Health, Province of Alberta, invites applications for the following positions: 1. **General Duty Nurses** — salary $3,240 to $3,720 per annum 2. **Supervisor Nurses** (preferrably with psychiatric nursing experience) — salary $3,540 to $4,080 per annum. 3. **Psychiatric Nursing Instructor** — to teach students taking a 3-yr. psychiatric nursing program, or to teach postgraduate nurses in an 8-wk. program — salary $3,960 to $4,680 per annum. Appointments to be made at active treatment hospitals, located at Edmonton & Ponoka, Alta. Residence, with board, if desired, $30 per mo. Excellent holiday, sick leave & pension programs. Apply: Supt. of Nurses, Provincial Mental Institute, P.O. Box 307, Edmonton, Alberta, or Provincial Mental Hospital, Ponoka, Alberta.

Nursing Arts Instructor for 170-bed hospital in University City (School of 80 students). Please apply: Director of Nurses, Victoria Public Hospital, Fredericton, New Brunswick.

Instructor (Qualified) to take charge of 12-wk. affiliation program in psychiatric nursing in a large private psychiatric hospital. Salary according to qualifications & experience. Apply Superintendent of Nurses, Homewood Sanitarium, Guelph, Ontario.

Instructor for 8-wk. affiliation program in large sanatorium. Salary according to qualifications. Good personnel policies. Apply Director of Nursing Service, The Beck Memorial Sanatorium, London, Ontario.

Classroom & Clinical Instructors (Immediately). Good Personnel policies. Please apply to: Director of Nursing, Victoria Hospital, London, Ontario.

Pediatric Head Nurse, Head Nurses for General Wards, **Operating Room Nurses,** (postgraduate or equivalent experience). **General Duty Nurses** for 110-bed hospital in Fraser Valley, 68 miles from Vancouver, good bus service. A new 90-bed wing will be finished early this fall. Accommodation is available in a lovely new residence opened February 1958. Personnel practices in accordance with R.N.A.B.C. policies. Further particulars available. Apply: Director of Nursing, General Hospital., Chilliwack, British Columbia.

Head Nurses & Registered General Duty Nurses for surgical, medical & obstetrical depts. Gross salary for nurses currently registered in Ont.: $235 per mo. — extra allowance made for head nurses. Good personnel policies. New facilities. Comfortable nurses residence. 8-hr. rotating shift, 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ day holiday allowed per mo., same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1 yr. service. Apply Superintendent, Lady Minto Hospital, Cochrane, Ontario.

Registered Nurses (6) for 52-bed hospital. Salary: $240-$275, according to experience. 5-day wk. No night shift. 3-wk. vacation with pay, after 1-yr. service. Apply: Superintendent, St. Louis Hospital, Bonnyville, Alberta.

Infirmières Licenciées (6) pour service général — sont désirées à l'Hôpital (52 lits). Les salaires: $240-$275 selon l'expérience. Service de 40 heures, sans service de nuit. 3 semaines de vacances payées, après un an de service, en plus des 10 jours durant l'année. Veuillez adresser toute correspondance: Les Soeurs de la Charité de N.D. d'Evron, Hôpital St. Louis, Bonnyville, Alberta.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $230 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered Staff Nurses (2) for a 12 bed hospital close to Banff. Salary $250. less $30. room & board. Rotating 8 hr. shifts. 40-hr. wk. 3 weeks holiday after a years service. Apply: Matron, Canmore Municipal Hospital, Canmore, Alberta.

Registered Nurses: General Duty, $240-$270 — **Staff,** $270-$300 — **Certified Nursing Aides,** $169-189, (Plus laundry) for large expanding city hospital in Edmonton for summer relief & full time employment. Experience available in all departments including operating rooms & case rooms. Credit given for postgraduate work & past experience. Opportunities for advancement. Liberal sick leave & vacation allowances. Fare will be advanced if necessary. For particulars apply to: The Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Registered Nurses (2) immediately for 30-bed hospital within 1-hr. drive from Waterton National Park, 20 min. from Lethbridge & 4 hrs. from Calgary & Great Falls, Montana. Salary: $260 per mo. gross. 44-hr. wk. 3-wk. vacation with pay after 1 yr. plus all statutory holidays. Straight 8-hr. rotating shifts. Health & pension plans available. Apply: Matron, Municipal Hospital, Magrath, Alberta.

Needed dedicated Christian **Registered Nurses** for Esperanza General Mission (22-bed hospital). Opportunities for witnessing for the Lord. Salary: $100 clear. 6-day wk. 10-hr. day. Apply Dr. H. A. McLean, Ceepeecee, Vancouver Island, British Columbia.

Registered Nurses: for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses — for 300-bed Medical & Surgical Sanatorium. Good personnel policies. Starting Salary $240 per mo. — 40-hr. wk. Accommodation available. Apply: Superintendent of Nurses, Fort William Sanatorium, Fort William, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered General Duty Nurses for County Hospital 45 mi. from center of Montreal with excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, bowling curling & dancing. 8-mi. from summer resort on Lake St. Francis & 12-mi. from U.S. border. Gross salary: $215 per mo. Three $5.00 increases at 6-mo. intervals to maximum $230. 44-hr. wk. 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 1-mo. annual vacation, all statutory holidays. 2-wk. sick leave. Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Quebec.

Registered General Duty Nurses (4) for 105-bed Pembroke Cottage Hospital as replacements for ones who have been married. Pop. of town, 15,000. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active interesting community social life in heart of the beautiful Ottawa Valley. Active ski club, curling club & skating, also the home of the famous Pembroke Lumber Kings Hockey Team, 2-theatres & a "drive-in". Nurses residence is available if desired, 2 blocks from the hospital. Gross salary: $210-$235 with increase at the end of 6-mo. & 1 yr. 3-wk. vacation, 7 statutory holidays. 14-day sick leave. No night duty. Blue Cross Medical/Surgical participation. Forward application to the Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered Nurses: for United Church Mission Hospital at Hazelton, B.C. An Opportunity for Christian service. Salary $235 per mo. Write — Administrator, Wrinch Memorial Hospital, Hazelton, British Columbia, or if in Toronto contact Dr. M. C. Macdonald, Board of Home Missions, 299 Queen St. West, Toronto 2B, Ontario.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $210 per mo., $5.00 increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts. 44-hr. wk. Many attractive benefits. Board & accommodation available at minimum cost in new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurses for an accredited 82-bed hospital. Salary: $255-$295 per mo. 40-hr. wk. & no split shifts. Living accommodation in nurses' residence & laundry of uniforms for $8.00 to $12.00 per mo. Apply: Superintendent of Nurses, Union Hospital, Canora, Saskatchewan.

Registered or Graduate Nurses, (2) trained Nurses' Assistant (1) for modern 20-bed hospital S.R.N.A. salary, schedule, 40-hr. wk. Increments after each 6 mo. service. Separate residence. Apply: Matron: Riverside Memorial Hospital, Turtleford, Saskatchewan.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for 105-bed accredited General Hospital. Salary: $330-$360 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Director of Nurses, Glenn General Hospital, Willows, California.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Wanted — Professional Nurses eligible for registration in Washington, D.C. Staff Nurse positions in 620-bed hospital for medical and surgical diseases of the chest; salary $4,080 per annum; $135 yearly increment; vacation, sick leave, retirement policies; 40-hour week; rotating shifts; active staff orientation program, progressive education programs for staff, student and patient personnel; uniforms laundered free; comfortable maintenance available at modest rates. Opportunity for university study. Write to Director of Nursing, Glenn Dale Hospital, Glenn Dale, Maryland.

Registered Nurses: for general duty in 50-bed general non-profit hospital, an opportunity to work & live in the Evergreen Playground, midway between Seattle, Washington & Vancouver, B.C. Base Salary $285 per mo. with increments, differential for evening, night & special services, 40-hr. wk. paid vacation, sick leave benefits & public holidays, liberal personnel policies. Apply: Administrator, Memorial Hospital, Sedro Woolley, Washington.

Registered or Graduate Nurses (2) for July 1st for general duty in modern 17-bed hospital beautifully situated on the west coast of Vancouver Island. Alternating shifts, 40-hr. wk. Salary: $260 per mo. less $40 full room & board. 1 mo. vacation with pay after 1 yr. service. All statutory holidays. Apply to: Matron, General Hospital, Tofino, British Columbia.

General Staff Nurses (Immediately) — Clinical Instructors in Surgery & Medicine (July) for new 288-bed modern hospital opened in January. School of Nursing with a present enrollment of 53 students. Comfortable nurses' residence. 40-hr. wk. Liberal personnel policies. Please apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

General Duty Nurses for small hospital. 40-hr. wk. $210 per mo. plus full maintenance. $5.00 per mo. increment every 6 mo. 1 mo. vacation with pay per yr. Please apply: Matron, Municipal Hospital, Raymond, Alberta.

General Duty Nurses, $255. 40-hr. wk. 28-day vacation yearly plus 10 statutory holidays. Sick leave 1½ days monthly, accumulative after 6-mo. Room & full board $25 per mo. Fare from Vancouver advanced or refunded after 6-mo. service. Apply Matron, St. George's Hospital, Alert Bay, British Columbia.

General Duty Nurse (1) for rotating shift (30-bed hospital) on or about June 1st. Salary: $260 per mo. less $40 for room, board & laundry. 40-hr. work wk. 4-wk. vacation with pay after 1 yr. service. 1½ days sick leave per mo. yearly accumulative. Attractive nurses' home adjoining hospital. Apply: Community Hospital, Grand Forks, British Columbia.

General Duty Nurses. Salary: $260-$312, $13 increment for experience. 40-hr. wk. 1½ day sick leave per mo. cumulative. 1 mo. vacation. 10 statutory holidays. Must be eligible for B.C. registration. Apply: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Graduate Nurses (2). Salary: $250. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $260-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Graduate Nurses (2) — for 30-bed general hospital in B.C.'s sunny interior. Salary $260 with annual increment — 42-hr. wk. 28 days annual vacation plus 10 paid holidays. Attractive nurses' residence. Board and room $45. Apply: Director of Nursing. Princeton General Hospital, Princeton, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling & skiing. Initial salary: $270. Maintenance, $45. 44-hr. wk. 4-wk. vacation with pay. Comfortable, attractive nurses' residence. Rail fare advanced if necessary. References required. Apply Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses. Starting salary: $260 per mo. & 4 annual increments of 5% to B.C. reg'd. nurses. $20 per mo. for one or more years university training & $10 per mo. for hospital postgraduate clinical training of not less than 4 mo. 28 days annual vacation after 1 yr. service, 10 statutory holidays per yr. 1½ days sick leave per mo. cumulative. Room rent at nurse's residence $20 per mo. Promotions to senior positions from permanent staff. For details apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Duty Nurses: Starting salary $260 — $312, for those with 2 yrs. nursing experience $273 annual increment $13, full maintenance $45 per mo., 10 statutory & 28 annual holidays, 1½ day's sick leave per mo. accumulative indefinitely, very active town, world famous Cariboo cattle country, annual Stampede. Apply: Director of Nurses, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. #18, Portage la Prairie, Manitoba.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for 55-bed hospital. Salary: $200 per mo. plus maintenance. Travelling expenses refunded on completion of 12 mo. service. Please apply: Director of Nursing, The Lady Minto Hospital, Chapleau, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $235 per mo. with annual increments. Good personnel policies with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $240 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses, Operating Room Nurse (willing to learn X-ray) for well-equipped 47-bed hospital. 8-hr. duty, 5½-day wk. Annual vacation with pay. Statutory holidays. Full maintenance in new modern residence. For further information apply: Superintendent, General Hospital, Kincardine, Ontario.

General Duty Nurses. O.R. Scrub Nurse (1). For modern well equipped 100-bed general hospital in friendly community. Gross salary: $240 per month if currently registered in Ontario. 8 hr. rotating shifts. 44 hr. wk. 1 day off 1 wk. and 2 the next. 21 days vacation after 1 yr. 7 legal holidays. Good personnel policies. Apply, Miss Willamene R. Allan, General Hospital, Port Colborne, Ont.

General Duty Nurses for 163-bed Tuberculosis Sanatorium. Good salary & personnel policies. Residence accommodation available. Please apply Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

General Duty Nurses for 100-bed modern hospital in south western Ontario. Please apply to: Director of Nurses, Tillsonburg District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurse (Immediately). Straight rotating, 8-hr. shift. For further information please apply to: Sister Superior, Hôpital Notre-Dame, Val Marie, Saskatchewan.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary: $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in psychiatry & pediatrics on a segregated service. Apply Superintendent, Community Hospital, Alamosa, Colorado.

Graduate Nurses for: 64-bed hospital, 250 miles north west of Edmonton. Salary $240 if registered in Alberta, less $30 for maintenance; $5 increment each 6 mo. for 6 increases, 4-wks. vacation with pay after one year service, plus statutory holidays, residence, $50 travelling expenses refunded after one year of service. Apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

Graduate Nurses: For new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses for permanent staff (2) summer relief (2). 8-hr. duty, 5½ day wk., rotating shifts. Accumulated 5 or 6 days following night duty of 2-wks. **Registered nurses** starting salary: $190 plus full maintenance. 1 mo. vacation after 1 yr. Popular summer resort. Apply: Saugeen Memorial Hospital, Southampton, Ontario.

Graduate Nurses (several) for future vacancies for modern 42-bed hospital in northern Ontario .Residential town, pop. 5,000 Over night by rail to Montreal & Toronto. Starting salary: $235 per mo. 40-hr. wk. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $320 with 4 annual increases to $360. Full maintenance $45 per mo. Liberal personnel policies. Apply Associate Director of Nursing Service, County General Hospital. Fresno, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital. Oakland 11, California.

Graduate Staff Nurse (Opportunities in the United States) for well-equipped 400-bed, non sectarian General Hospital affiliated with medical school. New salary rates: Dayshift, $340-$370 per mo., afternoon & nights, $370-$400 per mo. Comfortable, low-cost living accommodation available in attractive residence building. Apply to Director of Nursing Service, Mount Sinai Hospital, 2750 West 15th Place, Chicago 8, Illinois.

Operating Room Nurse and Registered General Duty Nurses for 100-bed General Hospital in attractive town on Lake Huron. Good personnel policies. Apply: Superintendent. Alexandra Marine and General Hospital, Goderich, Ontario.

Operating Room Nurses (2), General Duty Nurses for 60-bed General Hospital. Good salary. Paid life insurance & sick leave. Apply stating experience to: Director of Nursing, District Memorial Hospital, Leamington, Ontario.

Operating Room Nurses for 370-bed approved General Hospital with an intern-resident program. 7 theatres; 650 to 750 cases monthly. Starting salary: $330 or $340 per mo. according to experience. $20 per mo. merit increases at 12, 24 & 36 mos. 40-hr. wk. 2-wk. paid vacation. Paid sick leave, 7 paid holidays. Resort location in California's finest recreational area. Apply to: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Ave., Long Beach 13, California.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. $375 per mo. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Public Health Nurses: to commence August 1st. or September 1st. for Health Department, City of Calgary. Salary $3144 to $3816. 5 day wk. Pension & Sickness & Accident plans available. One Month's vacation after one yr. Apply: Dr. W. H. Hill, Health Dept., Calgary, Alberta.

Public Health Nurses required for City of Brantford. Salary based on experience. P.S.I., Blue Cross & Pension Plan available. Apply: Director, Brant County Health Unit, Brantford, Ontario.

Public Health Nurse (Qualified). Generalized program. Salary: $3,200 to $4,250. Annual increment: $150. Liberal car allowance. Apply to: A. E. Thoms, M.D., Director, Leeds & Grenville Health Unit, Brockville, Ontario.

Public Health Nurses: for generalized program with City of Chatham, Minimum salary $3200 5-day wk. Allowance for own car; Blue Cross, Windsor Medical Pension Plan & sick leave, 4-wks. vacation after 1-yr. Consideration given for experience. Apply: Supervisor of Nurses, City Hall, Chatham, Ontario.

Public Health Nurse (qualified). Generalized program includes some bedside nursing. Salary $3,200 to $4,250. Annual increment $150. 5-day wk. Car provided or car allowance. Apply: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses for generalized program in Seaway Development Area. Group insurance & Blue Cross available. Good transportation policy. Apply: R. S. Peat, M.D., Medical Officer of Health, S.D. & G. Health Unit, 38 Augustus St., Cornwall, Ontario.

Public Health Nurses — generalized program; minimum salary $3200 with allowance for experience, & annual increments. Generous provision for transportation. For further details write — Dr. R. M. Aldis, Director, Huron County Health Unit, Goderich, Ontario.

Public Health Nurse — generalized program, City of Guelph Health Dept. minimum $3,200 5-day wk. sick benefits, Blue Cross & P.S.I. benefits. Apply: Dr. Sutherland, City Hall, Guelph, Ontario.

Public Health Nurses (2) qualified. For a generalized program. 1, to be in charge, & 1 nurse for staff duty. Good salary. Generous car allowance. Duties to commence approximately August 15th. Apply: Gordon Cooper, Clerk, Township of Waterloo, Kitchener, Ontario. R.R.3.

Public Health Nurses (qualified) for generalized program, urban and rural. Salary $3,500 to $4,250. Annual increment $150, Pension plan, Blue Cross, 4-wk. vacation. Apply: Archie F. Bull, M.D. D.P.H. Director, Halton County Health Unit, Milton, Ontario.

Public Health Nurses (Qualified) for generalized program in city of 44,000. Starting salaries dependent on experience. 5-day wk. Month vacation. Blue Cross & P.S.I. employer shared. Accumulative sick leave & pension plans. Workmen's compensation. Group insurance. Transportation provided or car allowance. For further information please write, supplying details of training & experience to: Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurse (Qualified) for generalized program — Town of New Toronto. Salary range: $3,300-$3,800, starting salary depending upon experience. 5-day wk. Pension benefits. Sick leave plan. Blue Cross & P.S.I. benefits. Car allowance provided. Apply to: J. H. Miller, Municipal Clerk, Town of New Toronto, 185-5th St., New Toronto, Ontario.

Public Health Nurses (Qualified) for generalized program in suburb of Toronto. Minimum salary: $3,465. Starting salary based on experience. Car allowance: $670 per annum. 4-wk. vacation after 1 year. Pension plan, P.S.I. & Blue Cross benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 4946 Dundas St. W., Toronto 18, Ontario.

Public Health Nurses (Qualified) for generalized public health nursing service. Salary range: $3,388-$3,834. Starting salary based on experience. Annual increments. 5-day wk. Vacation, shared hospitalization, sick pay & pension plan benefits. Apply: Personnel Department, Room 320, City Hall, Toronto, Ontario.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Registered Nurses (2) for general duty, Salaries $250-$290 gross. $60 per yr. for experience up to 3-yrs. increments $5 per mo. for ea. 6 mos. service. Residence & laundry provided. $30 for maintenance. For policies & info. contact. Mrs. O. M. Nicholson, Sec. treas. Fairview Municipal Hospital, Fairview, Alberta.

Operating Room Nurse — Starting Salary $275 minimum with Postgraduate Course, $310 maximum with 3 yrs. experience or more. Iron mining town. Excellent accommodations & personnel policies. Transportation allowance after 3-mos. service. Apply: Supt. Lady Dunn Hospital, Jamestown, Ontario.

Supervisor (1) starting salary $264, less $33 for board & laundry; **Graduate Nurses** for general duty, **Registered Nurse (1)** for 3-11 P.M. Apply: Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ontario.

General Duty Nurses for: Operating Room, Obstetrics, Pediatrics, Medicine & Surgery: 40-hr. wk. Openings for Nursing Aides, eligible for certification in Alberta. For further information apply: Director of Nursing Service, Holy Cross Hospital, Calgary, Alberta.

Public Health Nurse: for generalized program 20 miles from Toronto. Salary range $3,250 — $4,000. Allowance for experience. 4-wks. vacation; cumulative sick leave; Blue Cross; Group Insurance; Pension Plan. Apply: Dr. W. E. MacBean, Director, Ontario County Health Unit (Southern Area), Pickering, Ontario.

Registered Nurse required for supervisory duty for a 60-bed modern up to date infirmary. Attractive salary & satisfactory working conditions. Board & accommodation on top of salary. Apply: Superintendent Jewish Old Folks Home, 146 Magnus Ave., Winnipeg, Man.

Registered Nurses required; medium 52-bed hospital in English speaking community 50 miles from Ottawa, Ont., Salary $192.50 per mo. with full maintenance, $10. extra for evening & night duty (2-wks.); Annual increase of 5% until maximum of $225 per mo. with full maintenance. Straight 8-hr. day, 44-hr. wk. statutory holidays, sick leave & annual leave. Fare advanced if required. Apply: Supt. Pontiac Community Hospital, Shawville, Quebec.

Graduate Nurses (3) urgently required for 8-bed Hospital in Southern Sask. Salary $260-$290 less $35 maintenance, 3-wks vacation, plus statutory holidays. 40 hr. wk. & bonus after 1-yr. of service. Travel fare advanced if necessary. Apply: Mrs. D. L. Knops, Sec. Treas., Rockglen Union Hospital, Rockglen, Saskatchewan.

Registered General Duty Nurses & Certified Nursing Assistants for new 58-bed hospital. Situated in North Western Ontario. Gross Salary $237 per mo. & $175 per mo., subject to increase after 6-mos. with regular annual increases thereafter. $45 per mo. room & board. Rail fare refunded after one year. New 21-bed nurses' residence-single rooms. Apply; stating age & when available to Director of Nursing, District General Hospital, Dryden, Ont.

Registered Nurses (2) for General Duty, 96-bed hospital; new modern residence opening this summer. $250 starting salary less $20 if not Sask. or Alberta Registration. $10 increments yearly for 3 yrs. For particulars contact Supt. of Nurses. Lloydminster Hospital, Lloydminster, Saskatchewan.

Registered Nurses (2) for general staff duty in 8-bed hospital. Employee benefits include a 5-day-wk., salary range from $250-$320 per mo. according to experience, as compiled by the Sask. Registered Nurses Association. Full maintenance available in nurses residence at $30 per mo. For further particulars address enquiry to B.E.L. Magnusson, Sec. Treas., Hodgeville Union Hospital, Hodgeville, Saskatchewan.

O. R. Supervisor wanted; preferably with postgraduate experience, also **General Staff Nurses, and Certified Nursing Assistants.** Good salaries & personnel policies, with residence accommodation available. Apply: Director of Nurses, General Hospital, Strathroy, Ontario.

Obstetrical Supervisor with postgraduate training required for 20-bed department in 106-bed hospital. Area of supervising includes case-rooms, ward and nurseries. Starting salary $300 plus differential equivalent to one annual increment (5%) for two years satisfactory experience which terminated within two years. Fare refunded after 6 months service. For information apply to: Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Registered Nurse (1) Full time to live in. Good salary & working conditions. Apply: Shelburne District Hospital, Shelburne, Ontario.

Instructor to be responsible for student rotations & assist with nursing arts instruction. Salary range: $3480-$4440 per annum. Liberal vacation with pay. Accumulative sick pay. Apply: Director of Nursing, Saskatoon City Hospital, Saskatoon, Saskatchewan.

Assistant Operating Room Supervisor (1) for an expanding service. Postgraduate work & experience essential. For particulars, please apply: Director of Nursing, The Royal Alexandra Hospital, Edmonton, Alberta.

Public Health Nurse for generalized program with Bruce County Health Unit, minimum salary $3200 with allowance for experience. Pension & Blue Cross Plans, also cumulative sick leave. 4-wks. vacation. Car provided if required. Apply: T. H. Alton, Sec.-Treas., Bruce County Health Unit, Walkerton, Ontario.

Registered Nurses (3) for 13-bed hospital. Starting salaries $260 per mo. Good personnel policies. Good travelling facilities — 60 miles from Winnipeg. Apply: Sister Superior, St. Claude Hospital, St. Claude, Manitoba.

Superintendent of Nurses (1) for a 31-bed hospital. Salary-minimum $310 gross per mo. Consideration given to one with special preparation. 3-room suite wih all new furniture in a new nurses' residence just decorated. Fully staffed on 40-hr. working wk. 2 doctors on medical staff. Duties to commence July 1, 1958. Town 2000 population. Situated on highway. Excellent transportation connections to Edmonton & Saskatoon via C.N.R. & C.P.R. Application forms, conditions & policies governing appointment available on request. Write or phone to Miss G. M. Vigneron, Supt. of Nurses or to Secretary Manager, Union Hospital, Unity, Saskatchewan.

Canadian Mothercraft Society offers a 3-mo. Postgraduate Course, including Truby King teaching in Mother and Child care & preparation for Natural Childbirth. Positions available in hospital & district work. Apply: Superintendent of Nursing, 49 Clarendon Ave., Toronto 7, Ontario.

Certified Nursing Assistants for immediate vacancies for modern 42-bed hospital. Residential town, pop. 5,000. Overnight by rail to Montreal & Toronto. Starting salary: $140 per mo. 44-hr. wk. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

The Ontario Society for Crippled Children

requires

EXPERIENCED PUBLIC HEALTH NURSES

GOOD SALARY RANGE

and

PERSONNEL POLICIES

For further information apply to:

THE SUPERVISOR OF NURSING SERVICES,
ONTARIO SOCIETY FOR CRIPPLED CHILDREN,
92 COLLEGE STREET, TORONTO 2, ONTARIO

Required by Jewish Hospital of Hope, 7745 Sherbrooke Street, E., Montreal, Que. **Nursing Supervisor** for 137-beds, operating room experience preferred. Excellent accommodation in nurses' residence, if desired. Phone Mrs. Durnford, Clairval 5-2847 between 9 & 4.30.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Matron: for modern 20-bed 5-bassinnette Hospital. Position open August 1st. S.R.N.A. salary schedule. Separate residence. Apply stating experience & references. Secretary-Manager, Riverside Memorial Hospital, Turtleford, Saskatchewan.

Registered Nurses: Salary $300-$315 with periodic increases. Good personnel policies. Further information contact Superintendent, Red Wing City Hospital, Red Wing, Minnesota.

NURSE INSTRUCTORS

required for Aug. 1, 1958

CENTRALIZED TEACHING PROGRAM

for

STUDENT NURSES IN SASKATCHEWAN

Classroom followed by Clinical program

(1) Prepared in Social Sciences (Psychology & Sociology)

(2) Prepared in Physical Sciences (Anatomy, Microbiology, Pharmacology)

S.R.N.A. Salary Schedule

Good personnel policies

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DIRECTOR, C.T.P.
REGINA COLLEGE, REGINA, SASKATCHEWAN.

GENERAL DUTY NURSES

required for our Company operated Hospital at Kitimat. If not registered in B.C. must be eligible for and willing to obtain B.C. registration on engagement.

Usual employee benefits.

Apply in writing to:

EMPLOYMENT SUPERVISOR
ALUMINUM COMPANY OF CANADA, LIMITED

KITIMAT, BRITISH COLUMBIA.

SECRETARY-REGISTRAR

required for

PROVINCE OF QUEBEC

Administrative ability and a knowledge of schools of nursing necessary.

Pension plan in operation.

Please apply in writing, stating qualifications, to:

BOX N, THE CANADIAN NURSE, 1522 SHERBROOKE STREET WEST, MONTREAL 25, P.Q.

REGISTERED NURSES (2) AND CERTIFIED NURSING ASSISTANTS (2)

for 34-bed general hospital, 40 miles north of Guelph, Ontario.

Please apply stating age & qualifications to:

SUPERINTENDENT,

LOUISE MARSHALL HOSPITAL,

MOUNT FOREST, ONTARIO

SUPERINTENDENT

Ontario registration, for Modern 22-bed Hospital. Previous experience as Superintendent not necessary. State qualifications, age & salary expected. Duties to commence at once.

Apply: Secretary-Treasurer:

BRUCE PENINSULA & DISTRICT MEMORIAL HOSPITAL, WIARTON, ONTARIO.

PUBLIC HEALTH NURSES

Generalized Program in Ottawa Area

Positions available for qualified Public Health Nurses for New Health Unit to open in August. Salary $3100-$3600 based on experience, Annual Increments $150, Hospital Plan, Pension Plan, Car provided or car allowance, 5-day.-wk., 3-wks. Annual vacation, 1-mo. annual vacation after 3-yrs. employment.

For information & application forms write:

WM. H. BRUNETTE, SEC.-TREAS., CARLETON HEALTH UNIT BOARD, COURT HOUSE, OTTAWA, ONTARIO.

REGISTERED NURSES — Growing medical centre in desirable 165-bed JCAH Memorial Hospital, Cheyenne, Wyoming. Home of Frontier Days rodeo & adjacent to Warren Air Force Base; near Denver. Hospital has plans for future expansion; liberal personnel policies — 40 hr. wk., 2-3 wks. vacation with pay; Nurses' Residence, board & room $43 per mo., Starting Salaries $275 day, $300 evening, $290 surgical.

Apply:

DIRECTOR OF NURSES, MEMORIAL HOSPITAL, CHEYENNE, WYOMING.

THE NURSES' CLUB LIMITED (In Liquidation)

SYDNEY — AUSTRALIA

Any person claiming to be a Shareholder of The Nurses' Club Limited (In Liquidation), Sydney, Australia, should communicate with the undersigned by 30th October 1958, when they may hear something to their advantage.

ALEX. R. COLVIN, 8 SPRING STREET, SYDNEY, AUSTRALIA.

PSYCHIATRIC NURSING INSTRUCTRESSES

required by

SASK. DEPT. OF PUBLIC HEALTH

for

SASK. HOSPITAL, NORTH BATTLEFORD

SALARY: $359 PER MONTH.

Requirements: **R.P.N. or Reg. N.** with postgraduate training in teaching & supervision. Consideration will be given to those who have registration in either field of nursing but who do not have the required postgraduate training but are interested in provisional appointments pending formal training for which financial assistance may be provided.

Duties: Appointees will serve as instructresses in a three-year, 600-hr. training program for student psychiatric nurses. They will give lectures, lead seminars, and give practical demonstrations designed to coordinate classroom theory and work on the wards.

APPLICATIONS: FORMS AND FURTHER INFORMATION AVAILABLE AT PUBLIC SERVICE COMMISSION, LEGISLATIVE BLDG. REGINA. APPLICANTS SHOULD REFER TO FILE NO. 5335.

Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

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COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$350 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

OPERATING ROOM SUPERVISOR
for
SAINT JOHN GENERAL HOSPITAL
(400-BED)

SCHOOL OF NURSING — 150 STUDENTS

QUALIFICATIONS: POSTGRADUATE CERTIFICATION IN OPERATING ROOM TECHNIQUE & MANAGEMENT WITH EXPERIENCE.

Apply to: Director of Nursing,
SAINT JOHN GENERAL HOSPITAL, SAINT JOHN, NEW BRUNSWICK

GENERAL STAFF NURSES

2 positions in the O.R. available in September
also positions in other Departments
200-bed General Hospital
Pleasant City of 33,000 - 3 Colleges
Good salary & Personnel Policies
Additional salary for postgraduate course
in operating room or obstetrics

For further information apply to:
THE DIRECTOR OF NURSES, GUELPH GENERAL HOSPITAL, GUELPH, ONT.

PEDIATRIC CLINICAL INSTRUCTOR

FOR

GENERAL HOSPITAL, SAULT STE. MARIE, ONTARIO

R.N.A.O. SALARY SCHEDULE

Apply

DIRECTOR OF NURSES, ST. MARY'S SCHOOL OF NURSING
SAULT STE. MARIE, ONTARIO

CLINICAL INSTRUCTOR

(Surgical Specialties)

SASKATOON CITY HOSPITAL

SALARY: $3,480-$4,440 PER ANNUM 40-HR. WK.

LIBERAL VACATION WITH PAY, CUMULATIVE SICK LEAVE.

Apply:
DIRECTOR OF NURSING, SASKATOON CITY HOSPITAL,
SASKATOON, SASKATCHEWAN.

INSTRUCTOR

to teach fundamentals of nursing. Student enrollment 83, minimum qualifications — experience in general nursing and certificate in nursing education.

REGISTERED NURSES

required for general duty staff in modern 300 bed hospital located in resort area in Canada's Chemical Valley. Sarnia, Ontario, is a progressive industrial city located at the junction of the St. Clair River and Lake Huron. Only minutes away are busy shopping areas, spacious sandy beaches, recreational and sports facilities.

The hospital is fully accredited and has approved schools for nurses, x-ray and laboratory technicians, and is approved for intern training.

APPLY BY LETTER TO PERSONNEL DIRECTOR,

SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

TO MEET A RAPIDLY EXPANDING HOSPITAL SITUATION: THE WINNIPEG GENERAL HOSPITAL IS RECRUITING

1. **AN ASSOCIATE DIRECTOR OF NURSING EDUCATION:**
   To supervise & assist in the organization & development of the educational program for the school of nursing.
   Qualifications:
   a. Minimum, a B.A., or B.Sc. degree in nursing with considerable experience in supervisory & administrative capacities.
   b. Desirable but not essential, a Master's degree or equivalent education & experience.
2. **AN OPERATING ROOM SUPERVISOR.**
3. **CLINICAL SUPERVISORS IN MEDICINE & SURGERY.**
4. **GENERAL DUTY NURSES FOR ALL SERVICES.**

Please send applications direct to: **THE DIRECTOR OF NURSING, THE WINNIPEG GENERAL HOSPITAL, WINNIPEG 3, MANITOBA.**

PUBLIC HEALTH NURSES (Grade 1)

BRITISH COLUMBIA CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centers in British Columbia. Salary: $290 rising to $345 per mo. Car provided. An opportunity for interesting & challenging professional service in this beautiful & fast-developing province. Competition No.: 57:591.

For information & application forms, write:
THE DIRECTOR, PUBLIC HEALTH NURSING, DEPT. OF HEALTH, VICTORIA, B.C. OR THE CHAIRMAN, B.C. CIVIL SERVICE COMMISSION, 544 MICHIGAN ST., VICTORIA, B.C.

B.C. CIVIL SERVICE COMMISSION

PROVINCIAL MENTAL HEALTH SERVICES, ESSONDALE, B.C.

SUPERINTENDENTS OF NURSES GRADE 1

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APPLY: DIRECTOR OF NURSING, OSHAWA GENERAL HOSPITAL OSHAWA, ONTARIO.

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For details, write to Civil Service Commission, Ottawa and quote:

Information Circular No. 58-805
For Registered Nurses

Information Circular No. 58-806
For Certified Nursing Assistants

Please specify the centre(s) in which you are prepared to serve.

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Further information may be obtained from the Director of Public Health Nursing, Department of Public Health, Provincial Building, Hollis Street, Box 488, Halifax, Nova Scotia, and application forms may be obtained from the

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(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

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